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BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

WASHINGTON, DC

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PREFACE

As the population of older Americans grows, so does the need and desire to provide comprehensive social services to this important segment of our society. For the past 25 years, the Older Americans Act (OAA), enacted by Congress in 1965 and reauthorized on 10 occasions, most recently in 1987, has improved the lives of our Nation's elderly and their caregivers. The OAA has authorized a wide array of essential social services and programs, ranging from congregate and home-delivered meals to the long-term care ombudsman and legal assistance services.

In anticipation of the 1991 OAA reauthorization, the U.S. Senate Special Committee on Aging conducted a series of four legislative workshops in 1990 that brought together Federal, State, and local government officials, social service providers, academics, and elderly persons who use social services. Workshop participants examined whether the OAA remains an effective and comprehensive response to the needs of the Nation's elderly population. The workshops, which focused on target populations, information and referral, long-term care ombudsman programs, legal assistance, and the role of the Administration on Aging, raised important questions for the reauthorization process and considered legislative options for improving the provision of social services to the elderly.

The central finding of these workshops is that the OAA continues to be a tremendous success in serving our Nation's elderly and their caregivers. We hope that these workshops not only shed light on the challenges facing the delivery of needed social services to America's elderly population in the 1990's, but through its recommendations will also assist the Congress in further strengthening the OAA.

During the course of the 1990 workshop series, older Americans lost a great friend in their struggle to maintain independence and dignity—Sparky Matsunaga (D-Hawaii). On April 16, 1990, Senator Matsunaga died after a long illness and Senator David Pryor, Chairman of the Senate Special Committee on Aging, dedicated this workshop series to his memory.

The Committee wishes to recognize the contributions of Committee staff in the production of this report, including Robert Rosen, Anna Kindermann, Heather Burneson, Diane Braunstein and David Barnhart, as well as John Monahan, Legal Counsel to Senator Pryor, and William Benson, Staff Director, Senate Labor and Human Resources Subcommittee on Aging. We also wish to recognize the assistance of the U.S. General Accounting Office, particularly James Solomon, Sushil Sharma, Patrick Grasso, and James Musselwhite, and the Congressional Research Service, particularly Carol O'Shaughnessy.

SUMMARY OF WORKSHOP I

REAUTHORIZATION OF THE OLDER AMERICANS ACT

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

WASHINGTON, D.C.

JANUARY 31, 1990

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INTRODUCTION

In anticipation of the 1991 reauthorization of the Older Americans Act (the OAA or the Act), the U.S. Senate Special Committee on Aging, in collaboration with the U.S. General Accounting Office (GAO), conducted the first of four workshops to examine the efficacy of the Act in its present form and to consider legislative options for improving social services offered to elderly Americans. Since 1965, the Act has authorized many diverse and complex services and programs, including nutrition, employment, information and referral, transportation, etc. This informal workshop, and those that follow, examine whether the Act remains appropriate for the needs of the elderly in the 1990's.

This first workshop broadly considered three critical areas of the OAA: target populations, services, and structure. Distinguished panelists addressed each of these issues in turn, followed by an informal discussion between the speakers and the audience. The following chronology details the questions raised, the issues discussed, and the options proposed for amendment to the OAA.

OPENING REMARKS

Senator David Pryor, Chairman, Special Committee on Aging. (pp. 117–119)*

This workshop has a dual purpose:

(1) To examine the services authorized under the Act; and

(2) To suggest possible legislative options for the 1991 reauthorization. The workshop is not a formal hearing, but an informal discussion. Today, the aging network in America consists of all 50 States, 670 area agencies on aging, and 25,000 service providers working together to provide social services and assistance to the elderly community.

President Bush's current budget proposals for the OAA include cuts of approximately $14 million from Title V employment programs as well as a freeze of all other OAA programs at fiscal 1990 post-sequestration levels. Nevertheless, the OAA continues to be a "helping hand" to the elderly, with a guiding principle to help senior citizens maintain their independence and their dignity.

This workshop is the first step in the examination of the OAA to determine whether the OAA works as well as it could, whether the Act still meets the needs of older Americans, and what changes might be appropriate. This workshop will consider reauthorization of the OAA from three perspectives:

1. Target Populations (pp. 121–129)
2. Services (pp. 130–145)

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*Reference is to the applicable pages of Workshop I transcript where the full text of the summarized pages appears.

3. Organizational Structure (pp. 146–155)

James Solomon, Senior Assistant Director, Program Evaluation and Methodology Division, General Accounting Office. (pp. 119–121)

The 1991 reauthorization of the Act comes at a crucial time in its history:

1. The number of elderly is increasing substantially, particularly the number of old-old (age 75 or older) and frail old (limited in performing personal care or home management activities), creating a population that must be served.
2. Although the number of service providers is increasing, it is not increasing at the rate necessary to meet all the needs.

The reauthorization of the Act requires a consideration of how these trends converge and how the Act can best meet its needs. This workshop is the beginning of that process.

A. *Objectives of the Workshop:* (p. 120)

1. To raise important questions.
2. To propose and assess options for responding to key issues that may merit particularly close attention as part of the reauthorization process.

B. *Unifying Themes of the Workshop:* (p. 121)

1. *Advocacy.*—Whether the agencies and individuals mandated to serve as advocates are effectively providing such service.
2. *Efficiency and Effectiveness.*—Measure whether services are being provided in an efficient, appropriate, and cost-effective manner.
3. *Gap-Filling.*—Provide information or services that are not being offered by other programs or institutions.
4. *Equity.*—Serve the persons who have the greatest need.

PANELIST PRESENTATIONS

Dr. Percil Stanford, Professor, Center of Aging, University of California at San Diego (pp. 122–125; prepared statement pp. 126–129)

TARGET POPULATIONS

The preamble to the OAA asserts that the Act's purpose is to provide assistance in the development of new or improved programs to help older persons through grants to States for community planning, services, and training. The OAA was at least 20 years behind the times at its initial stage. The years since its enactment have been a process of modernizing the Act to reflect the changing demographic profile in society. (pp. 122–125)

Under Title I of the OAA, which spells out the Act's intent, older people are entitled to and it is the responsibility of the U.S. Government and their political subdivisions to assist older people in securing an opportunity to a full and free enjoyment of the objectives presented in the Act. Old minority individuals do not enjoy such an opportunity. One of the first considerations in the reauthorization of the Act should be to scrutinize how the broad objectives of the Act provide for the inclusion of race, color, culture, and ethnicity. (p. 122)

A related issue, which must be considered in the reauthorization of the Act, is whether populations "melt." Today's society is not becoming more assimilated and homogeneous. Rather, there is growing support for the co-existence of different cultures and races. To best serve older people, the Act should explicitly acknowledge that diversity has positive qualities. The emerging concept of "diverse life patterns" should be included in the language of the Act, recognizing the differences between older individuals and their collective life experiences. (pp. 123, 125)

State and local agencies under the OAA are then free to look at the specific needs of targeted populations and develop programs and allocate resources accordingly. In addition to race and language, the higher proportion of poverty among certain minority elderly groups should figure into the targeting analysis. This targeting of diverse age populations is the key to ensuring that older people in greatest social and economic need receive needed attention. Also, targeting will ensure more equitable distribution of resources. (pp. 123, 124)

To ensure that there are sufficient resources and to support the States' efforts, the reauthorizing language should include very specific guidelines for developing targeting formulas and for standardizing funding formulas. These specific guidelines go with the Act's mandate to target services to minority older persons and those in greatest need. (pp. 123, 124)

To then adequately provide services to the targeted groups, the Act must emphasize education, training, and research to bring about positive changes in the aging network. Major responsibility for the development of trained and educated personnel from targeted groups to serve the elderly of those targeted groups must come from the public sector. Research is required to monitor and understand the changes occurring within the targeted populations. (p. 124)

The following are a few of the key issues that impact on the quality of services and the quality of life of targeted populations: (pp. 124, 125)

1. *Home Care.*—Greater support for the homebound is called for by the growing number of elderly remaining at home. The Act must allocate more resources for assistance with Activities of Daily Living (ADLs) (e.g., personal care and home management activities such as bathing, dressing, walking, shopping, managing money, preparing meals, etc.). (pp. 124, 125)
2. *Transportation.*—Assistance continues to be needed for reaching medical services and therefore, consideration must be given to devising ways of funding transportation costs. (pp. 124, 125)
3. *Employment.*—Older persons increasingly are re-entering the labor market. Many older minorities in targeted populations have not had good work histories and would unlikely be employed based upon previous work experience. Further, the recent emphasis upon volunteerism for older people is not widely received because older people, in need of a supplemental income, cannot afford to volunteer nor do they come from backgrounds where volunteering is the norm. (p. 125)
4. *Retirement.*—The language in the Act should refer to quality of life after work. A high percentage of older minority and culturally diverse persons do not have the benefit of experienc-

> ing retirement in the traditional sense. The influence should be that there are programs and benefits available to persons who reach the point where they no longer need to work on a full-time basis. (p. 125)

These considerations require that further efforts be made to reach and serve all targeted populations by understanding and developing programs based upon diverse life patterns and not the "melting pot" or assimilation ideas. (p. 125)

Dr. Robert B. Hudson, Professor, School of Social Work, Boston University. (pp. 130, 135; prepared statement pp. 136, 145)

SERVICES

Is the legislative intent of the OAA presently being met and what, if any, alterations might be in order to enhance service delivery? (pp. 136, 137)

CENTRAL ISSUES

1. *The Vague Language of the OAA.*—Title I enumerates 10 objectives that are laudable yet beyond the reach of the organizations that operate under the Act. At the same time, the recent trend toward increased earmarking provides an odd mix for those charged with administering the OAA programs. To what extent were the operational missions of the Act to be: (a) the contracting for social services; (b) the development of a comprehensive and coordinated services system; and/or (c) an advocate for elders with the public, legislators and other agencies? (pp. 130, 137)

2. *The Twin Mandates of the OAA.*—On the one hand, there has been an inward looking services delivery mandate, calling upon the agencies to set up and oversee some kind of delivery system of their own. On the other hand, there has been an advocacy pooling and leadership planning effort which have the State and area agencies looking beyond their immediate confines. (pp. 131, 137)

It may be both an easier and a more appropriate effort for agencies to build a services network as best they can with limited resources rather than pursue advocacy efforts elsewhere.

3. *Eligibility.*—The tension here is how to be true to the spirit of the Act (e.g., all persons over 60 should be eligible for services) and yet meet the more specific strictures elsewhere in the Act that targeted populations should be especially served. (pp. 131, 138)

4. *Vertical Structure.*—Various mandates are given to the Administration on Aging ("AOA") in Washington and to the regional agencies while other mandates are given to the State and area agencies:

    1. *Washington mandate.*—AOA is charged with pursuing the broad goals of Title I and yet must also see to it that many of the more specific earmarking is undertaken as well. (p. 131)
    2. *State mandate.*—A State, in addition to building its plan on top of all the area plans, is mandated to engage in advocacy activities at the State level, serving as an effective and visible advocate for purposes of the Act. (p. 131)
    3. *Area mandate.*—The area agencies are charged with developing a comprehensive and coordinated services system, yet

the list of mandated services (adult day-care, in-home services, case management) varies from that of the States. (pp. 131, 132)

In sum, the Act has been both too vague and too specific. Although some beneficial services are provided through efficient systems, the agencies have not been able to establish comprehensive and coordinated service systems on their own that meet the service system mandate. (p. 132)

On the positive side of the ledger, the nutrition program has proved very useful to the elderly and to furthering the organizational place of the agencies responsible for implementation. The program provided tangible and real results, which went far beyond nutrition and served the organizational needs of the agencies involved. (pp. 132, 133, 141)

RECENT CHANGES

A number of social changes have occurred on the macro level: elder population growth; nursing home population growth; growth in State budget allocations for Medicaid; the rise of new proprietary agencies getting involved in aging and long-term care activities; the strain on community-based agencies dealing with the elderly caused by various cost constraint initiatives which increase early hospital discharges. (pp. 133, 142)

These changes require an administrative structure that can begin to address these issues. Many of the agencies operating under the Act are developing a role in home-care and community-based care. These agencies are community-based; they are aging-focused; they are logically placed throughout the States and staffed with growing numbers of qualified individuals. Examples: OAA agencies in Illinois, Wisconsin, Massachusetts, Oregon, and Arkansas are engaged in community-based care. (pp. 133, 134)

OPTIONS FOR REAUTHORIZATION (PP. 131–142, 140–142)

1. *Two Key Issues.*—First, whether agencies should get involved in case management functions? Is that a direct service precluded by the OAA language or is it an indirect service? Second, the so-called "creaming phenomenon" where an agency, in competition with rising proprietary efforts, explores the idea of fee-for-service, enter the private market and end up serving the more affluent or the less frail clients. The counter argument contends that in today's society, agencies can only meet their traditional mission if the private sector resources are available to them. (pp. 134, 142, 143)

2. *State-Level or Horizontal Structure.*—The big public dollars for community-based long-term care are State dollars, not Federal dollars. The horizontal structure, rather than the top down categorical grant model, must be considered in the reauthorization process. (pp. 134, 135, 144)

3. *Avoid Over-Categorization.*—To the extent that specific service dollars are earmarked for specific populations, meeting larger functional needs will be increasingly difficult. The OAA should not be discarded in favor of a block grant because of the useful network currently in place. (pp. 135, 144)

4. *Target Populations.*—Concurs with Dr. Stanford regarding the disadvantaged groups and the strengthening of the OAA's language. (p. 135)

5. *Title II.*—Increase the resources and heighten the visibility of th AOA in order to achieve two goals—first, to work with agencies that can aid State and area agencies in their efforts at home and community-based care; and second, to have the resources and personnel to enable it to become a think tank for those in Washington interested in these issues. (p. 135)

Dr. Robert Binstock, Henry R. Luce Professor of Aging, Health, and Society, Case Western University (pp. 146, 150; prepared statement pp. 151-155)

STRUCTURE

Proposal.—A new role after the aging network of agencies funded under Title III, perhaps at no additional cost—a role as a highly visible, nationwide, inter-community network of Aging Resource Centers (ARC). (pp. 146, 151, 152)

The Title III agency network has been an excellent vehicle for identifying the challenges of an aging society and for providing help to millions of Americans. The political environment that nourished this program no longer exists. Congressional leaders have begun to ask whether the funds appropriated for Title III might be used with greater leverage or in a different fashion. (pp. 146, 151)

Changes in the OAA have been minor. During the reauthorization process, the aging network needs to be examined in the light of some very basic issues. What is the most useful role the network might play? Could the objectives of the Act be better met by expending Title III resources in a different fashion? (pp. 146, 152)

Many of the services once provided by the Title III network are today provided by public, nonprofit, philanthropic agencies and profit-making agencies. What is missing for most elderly is knowledge about where and how they can get help. The most pressing need in our society is for a highly visible, distinctive site in every community that is part of a nationwide, intercommunity network of such sites to which older persons can turn to begin the process of getting help. (pp. 146, 147, 152)

The Title III network is ideally situated to fulfill the general need for this kind of help if it can become more visible in a uniform nationwide fashion. In 1991, the network should be converted into this nationwide network of aging resources centers. (pp. 147, 152)

Each ARC would: (1) serve as a source of initial contact and practical information; (2) provide emergency responses, if warranted; (3) for complex, nonemergency responses, undertake extensive information gathering, assessments, planning, and assistance and then implement referrals; (4) track progress at prescheduled intervals; (5) re-intervene if referral proves ineffective and find the client another alternative; (6) regularly analyze aggregate activities to provide administrative accountability to AOA, maintain congressional support for the ARCs, and identify gaps in the availability of essential services; and (7) fill the gaps in local services through system capacity building. (pp. 147, 148, 152, 153)

These activities should become the sole responsibility of the network. Agencies involved in the provision of direct services cannot perform this function. The Title III network requires three characteristics to make it suited for this new legislated role (pp. 148, 152):

1. High visibility;
2. Smooth on-going collaborative relations with existing community agencies; and
3. Leadership in developing further services.

The network would have to withdraw from the role of service providing because substantial funds would be needed to make an effective transition to a network of ARCs. Absent an increase in Title III funding, the current funding would need to be reallocated and appropriated for the ARC's. (pp. 148, 152)

Advantages of the ARC Network: (pp. 148, 149, 153, 154)

1. The probability that older persons and their families will get help, and the quality of that help, will be improved.
2. Routine ARC functions would enable clients to receive appropriate help within the framework of existing public policies and philanthropic agencies or through the private market.
3. Elimination of the network's direct services would reduce redundancy among services now offered by various providers.
4. Through ARC dealings with their clients, a running record of gaps in the provision of services would be established which the ARCs can use to undertake leadership in developing these missing resources.
5. ARCs would build up a strong reservoir of public political support, allowing long-term effectiveness and adding to the capacity of other agencies to provide help to their clients.

Disadvantages of the Transition to ARC Network: (pp. 149, 154)

1. If services that are currently provided were phased out, they would not be immediately available from other sources in the next term. But leadership of the ARCs would quickly lead to the redevelopment of these services.
2. Transition to the ARCs would render obsolete certain service providing agencies and personnel, although the latter could be reoriented to ARC activities.

Prerequisites for Transition to NRC Network:

1. *Amendment to the Act.*—Congress should specifically mandate in the OAA language that the funds now used for services be authorized and appropriated for the operation of the ARCs. Dr. Binstock referred the audience to the text of his prepared statement for details of the following prerequisites for transition. (pp. 149, 154)
2. *Arrangements for Confederation and Collaboration.*—Developing an effective ARC requires the formation of specific confederative arrangements with the major private and public sector agencies involved with services to the elderly. (p. 154)
3. *Major Publicity Campaign.*—The effectiveness of the ARCs will depend heavily upon their visibility and their accessibility. Where the ARC is, what its function is, and how one contacts

it must become common knowledge among older Americans. (pp. 154, 155)

4. *Structural Elaboration of the Network.*—Especially in rural areas, the development of additional ARC sites will be needed over time. (p. 155)

5. *Reorientation of Network Staff and Staffing Patterns.*—This aspect of transition requires intensive staff orientation sessions using national and local training modules that clearly delineate resources, policies, and responsibilities at each level. (p. 155)

One exception to this proposal is the nutrition program. This is the one set of existing services that can be maintained within the existing network because it is not particularly redundant and because it would counter network resistance to the new role as ARCs. (pp. 149, 154)

Assuming that the money will not be appropriated to perform the more than 30 specific services authorized in the Act, ARCs are the most useful role for the agency network. (pp. 150, 155)

PARTICIPATION FROM AUDIENCE

Dr. **Stanford**: There are pockets around the country where there is a complete lack of services. More attention must be given to knowing what the gaps are and how the needs can be met in ways appropriate for those particular populations. (pp. 156, 157)

The problem is that the Act's guidelines for determining eligible elderly leave gaps where whole regions are without services. The agencies cannot justify the additional expenditures to meet the needs of those particular people excluded under the OAA. The reauthorization process should consider "standard exceptions" to the Act's eligibility guidelines to provide services to those in need. (pp. 156, 157)

Dr. **Binstock**: The whole notion of the network trying to provide services forestalls getting services the right way (e.g., Medicaid's inadequacy in reimbursing a sufficient range of home services). The home care gap should not be filled through the OAA, but rather through amending Medicaid. (p. 157)

Mr. **Solomon**: What do we know about the relative efficiency and effectiveness of direct services as opposed to service referral? (p. 41)

Dr. **Hudson**: At some point you need both. The issue is really one of packaging and different ways of providing service packages. First, identify the needs of a client, determine the capacity of the system to meet those needs, and work toward creating the linkages that an ARC might be able to make. (p. 158)

Mr. **Don Edwards**, Commission on Aging in Alexandria, VA: To get leadership for enablement depends upon providing the agencies with the necessary funding. All the other goals articulated require resources. The Title III budget must be increased and the network must work to make more funds available. This is a matter of priority—where are the available funds spent? (pp. 158, 159)

Also, the AOA director was nominated last November, but has not yet been appointed. In the meantime, a 1991 White House Conference, preceded by State conferences in 1990, is needed. How does this kind of activity get started so that the proposals made in the course of this workshop become available to a nationwide audience? (p. 159)

Dr. **Binstock**: The ARCs are not Information and Referral. Rather, the ARCs are what I and R should have been, but never has been. The ARCs have more functions. The agencies will have the incentive to cooperate with a highly visible intake source because they will get excluded from the network otherwise. (p. 159)

As for the Commissioner on Aging, it is a minor bureaucratic position although it started as one with potential to be important. To change the current status quo would require a total reorganization of structure. The Act should move toward a Secretary on Aging and a Department of Aging. (pp. 159, 160)

Mr. **Mohamed Al-Ibrahim**, Faculty Physician, University of Maryland, Baltimore. (p. 160) Agreed with the ARC proposal and added two comments:

(1) Undergraduate education is a critical area for support. Specific dollars should be spent in innovative changes in the curriculum so that students come into contact with the issues they will be called upon to confront later.

(2) The acute care hospital is a good place to locate the frail elderly: the information that can be conveyed will assist in identifying those in target populations. The use of the emergency room by urban senior citizens is equally important for targeting purposes.

Dr. **Binstock**: The State units would administer the set-up of the ARC's in the States, i.e., structuring of funding formulas, reorientation, and in-service training. Also the State units would play a central role in filling the gaps, taking the leadership responsibility, and mediating among the various areas and their needs. (p. 161)

Ms. **Gail Martin**, National Association of Meal Programs: How do all the pieces fit together under these new proposals? How is the network to be coordinated? (pp. 161, 162)

Dr. **Binstock**: The system is not to be a coordinated one—

1. Comprehensive coordinated systems are counter to this country's political system of fragmentation. (p. 162)
2. An ARC, neutral and public spirited, would attempt to maximize the resources through dealing people to the appropriate places so they find a person eligible for a particular program or service. (p. 162)

Ms. **Martin**: Some areas are not covered by certain programs and services. Are services to be expanded to that area in a coordinated fashion? What methodology is there for incorporating services presently lacking because certain areas are not within the information loop? (pp. 162-163)

Dr. **Binstock**: The ARC network will provide a clear record of what is missing and what has been provided, and also offer leadership and collaboration with the private and public agencies as well as the corporate sector. The ARC network will fill the gaps. (p. 163)

Debra Wertheimer, Physician, University of Maryland: (pp. 163-165)

1. *Discharge Planning and the OAA.*—Information of available resources for elderly Americans should be easily passed between persons providing services and those persons who have accumulated what resources are available in the communities. Absent the OAA, many services would not be available in Maryland so that

these services would not be picked up if the ARC plan were adopted. (p. 164)

2. *Preventive Health Care.*—Preventive health care is not reached with the kinds of resources that older Americans deserve. If the OAA looked to preventive care, much of the post-hospital expenditure of resources would be reduced. The OAA is not achieving this goal, which is attainable through such places as nutrition centers. (p. 164)

3. *Education.*—In addition to the poor state of medical education, the health disciplines do not work well. Through multidisciplinary and inter-disciplinary groups, the health disciplines should learn what each other are doing and how they can avoid duplicative services while still providing necessary services. (p. 164)

4. *Research into the Elderly.*—Through research, many of the disabilities that the Act must now address can be prevented (e.g., increased functional capacity through weight reduction).

Dr. **Hudson**: At the State level and at the Washington level, strong leadership is necessary, as in Oregon and Arkansas, to work with State public health departments in order to inform and assist whatever is to occur at the area level. (p. 165)

Dr. **Binstock**: (1) Regarding the provision and lack of information, one of the prerequisites to the ARC network is reorientation of network staff and staffing patterns including periodic inservice training and updates of training materials. (p. 165)

(2) Regarding the cut-off of services with no one to pick them up during transition, any structural change such as the ARC network proposal carries with it a trade-off and some pain. Entities such as counties and cities, etc., will pick up these services. (pp. 165, 166)

If there were no network services to which community agencies could abdicate their role as service providers, then the role of these community agencies, which are not currently picking up even the essential services, would be different. (p. 166)

Dr. **Stanford**: (1) Tone of the Language Adopted: Many of those in the targeted populations suffer from poor health conditions. The tone of the current OAA suggests continuous response to crisis situations. Rather, the focus should be upon prevention, a more positive approach. (p. 166)

(2) Services from a Team Perspective: The language of the Act should emphasize a methodology that will assist systematic cooperation and coordination in the provision of needed services. (p. 166)

Mr. **Jim Bergman**, Executive Director, Healthways Foundation of New Jersey: (pp. 166–168) The key issues for reauthorization are leadership, targeting, focus of the OAA services on the rights and autonomy of individuals, and enhancing efforts of the aging network to utilize outside resources. This is reauthorization without substantial amounts of new money. Therefore, the tone and language of the Act are essential. (p. 167)

(1) *Leadership.*—The thrust of the Act should be high level leadership, with possible incentives in the Act to encourage States to set up Cabinet Offices of Elder Affairs. The tone of the Act should reflect this emphasis on leadership with explicit language upgrading the AOA to Cabinet status. (p. 167)

(2) *Targeting.*—Area agencies are having difficulty understanding what the Act means when spending their money to meet the needs articulated by the Act. In the Act, go beyond saying social and economic need and give specific examples of the "hidden elders", e.g., people in nursing homes and mental institutions. Targeting can mean specific examples. A person must be in need, but if they are in specific categories, they should be targeted for OAA services. (pp. 167–168)

Also, targeting means priority for service, not putting a person identified as abused or neglected on a waiting list for services. The Act can provide directly for this if it gives explicit examples of target populations. (p. 168)

(3) *Agency Efforts at Getting Outside Resources.*—The Act needs to: (1) put money into building stronger relationships between the private and public sector; and (2) maximize the flexibility of area agencies in getting public and private sector money. The ARC proposal is the wrong direction. (p. 168)

Dr. **HUDSON**: The creation of a Secretary on Aging in Washington is really an issue of leadership and could proceed just as easily by investing a Commissioner within the Department of HHS with certain authority. (p. 169)

How can an increased interest in aging populations, flat funding and increased flexibility of area agencies to do more all be achieved? (pp. 169–170)

Mr. **BERGMAN**: Although Cabinet level status is no guarantee of leadership, the question is where is leadership more likely to assert itself. It provides a pulpit for the Cabinet Secretary not available to an HHS Commissioner. (pp. 169–170)

Targeting does not mean spreading limited resources in more directions. Rather, the Act should be more specific about who are vulnerable populations within that socially and economically deprived group in need. Explicit examples of different categories will provide leadership and essential flexibility to the area agencies struggling under the vague language of the current OAA. These examples are not mandates. Case management does make sense within the area agencies if they want to do it. (p. 168)

Dr. **HUDSON**: The $200,000 per year that go into the Federal Council, and maybe a few million more put into a policy analysis center in the AOA, could yield the kind of leadership and targeting specificity suggested by Mr. Bergman. (p. 171)

Dr. **STANFORD**: The White House Conference importance is a very long range proposition. There is value in moving ahead: (1) to help us look at not only the 1990's, and (2) what preparations are needed for the 21st century. (p. 171)

Mr. **SUSHIL SHARMA**, General Accounting Office: The Act speaks to provision of services to an indeterminate number of people. The inhibited flow of information means that a true national estimate of needs is lacking. Notwithstanding that, should the Act's reauthorization process be concerned with more specifics, e.g., the ombudsman program? The Act says nothing about how many ombudsmen are to be provided to elderly people, how they are to recruit their volunteers nor what background they are to have. Can the objectives of the Act be accomplished if the reauthorization process fails to get specific? (p. 172)

Dr. BINSTOCK: To specify the qualifications of the ombudsmen, the Act should earmark funding for a joint ombudsman training program through the universities. Then, beyond the legislation, there should be a good reporting system set up to show what is being achieved. (pp. 172–173)

However, the ombudsman legislation should not be in the OAA. The function, though enormously important, could be placed in State or Federal public health legislation. (p. 173)

Dr. STANFORD: This is another example of the leadership question. Through training and support research, people learn the general guidelines for moving ahead while still maintaining the necessary flexibility to function effectively. (p. 173)

PANELIST PERSPECTIVES ON FUTURE WORKSHOPS (PP. 174–177)

Dr. STANFORD: What the targeted populations really are. What are some of the broad examples that can be used as guidelines? Once the mechanisms and methodologies are in place for provision of care, then we can determine what services are needed. Also, model and demonstration projects will provide insight into potential future successes or failures. (p. 174)

Dr. HUDSON: Three areas—

(1) How great is the diversity within the network between State and area agencies? (pp. 174–175)—Specifically, look to the dozen States doing serious work in home and community-based care involved with Medicaid. (p. 175)

(2) Regarding the ARC's, can case management effectively be done by itself by a free-standing case agency lacking other resources, other services, and other ties to the political and service community? (p. 175)

(3) A focus upon the revitalizing of the AOA and some of the related issues such as Cabinet Secretary, etc. (p. 175)

Dr. BINSTOCK: (1) *Targeting.*—Targeting is a political problem at the national and the State level. Also, the potential for standardized intrastate funding formulas should be explored in a workshop setting. Are there some areas where targeting can be more focused than others? (pp. 175–176)

(2) *Leadership.*—There should be some specification in the Act to achieve this leadership goal for area implementation. The related issue of recruitment potential could serve as a workshop topic as well. (p. 176)

(3) *ARC Network.* (pp. 176–177)

LEGISLATIVE RECOMMENDATIONS

The following is a list of all the specific recommendations for the OAA offered by the panelists and the participants of the first workshop.

TARGET POPULATIONS

1. The broad objectives of the Act must provide for the inclusion of race, color, culture, and ethnicity. The concept of diversity in life patterns among the elderly should be incorporated into the Act's

language and the "melting pot" model should be abandoned. (pp. 4–5)*

2. The Act should include very specific guidelines for developing targeting formulas and for standardizing funding formulas in order to serve those in greatest need with the limited resources available. (p. 5)

3. The Act should emphasize education, training and research to effect positive change in the aging network and to adequately provide services to the targeted groups. (p. 5)

4. The Act must allocate more resources to assist with home care, transportation costs, and the problem of a growing class of elderly re-entering the labor market. (pp. 5–6)

5. The home care gap should not be filled by the OAA but rather by amending Medicaid. (p. 10)

6. The Act should authorize specific expenditures for undergraduate education so that younger people are exposed to the problems confronting the elderly. (p. 5)

7. The thrust of the Act should be high level leadership, including explicit language elevating the Commissioner of the Administration on Aging to Cabinet status. (p. 11)

8. The Act should go beyond broad targeting language and give specific examples of those persons considered to be the vulnerable populations within the socially and economically deprived group. (p. 5)

SERVICES

1. The increasing role of State money in long-term community-based care antiquates the categorical grant model for agencies under the Act. The horizontal structure, or State-level model, should be considered in the reauthorization process. (p. 7)

2. The OAA should not be discarded in favor of a block grant because of the benefits enjoyed from the extensive network operating under the Act. (p. 7)

3. The Act should authorize an increase in the resources for the Administration on Aging under Title II and heighten its visibility to promote the Act's goals. (p. 8)

4. The reauthorization process should consider establishing "standard exceptions" to the OAA eligibility guidelines to serve those elderly in need who are currently excluded by the Act. (p. 8)

5. The OAA should consider preventive care measures to minimize the post-hospital expenditure of resources. (p. 12)

6. The language of the Act should establish a methodology that will assist systematic coordination and cooperation in the provision of needed services. The tone of this language should be positive, focusing upon preventive care, rather than upon crisis situations. (p. 12)

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*Reference is to the pages of the summary where these proposals are described in greater detail.

STRUCTURE

1. The OAA's agency network under Title III should become a highly visible, nationwide, inter-community network of Aging Resource Centers. (p. 8)

2. Congress should specifically mandate in the OAA language that the funds now used for services be authorized and reallocated for the operation of this new agency network. (p. 8)

3. The Title III budget should be increased and the agency network should work to make more funds available. (p. 8)

4. The OAA's current agency network should be more active in obtaining outside resources. The Act should put money into building a relationship between the private and public sectors and should also maximize area agency flexibility in getting public and private sector money. (p. 9)

SUMMARY OF WORKSHOP II

REAUTHORIZATION OF THE OLDER AMERICANS ACT

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

WASHINGTON, D.C.

APRIL 19, 1990

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INTRODUCTION

In anticipation of next year's reauthorization of the Older Americans Act ("the OAA" or "the Act"), the U.S. Senate Special Committee on Aging conducted a series of workshops in 1990 to examine the efficacy of the Act in its present form and to consider legislative options for improving the provision of social services to older Americans. Since 1965, the Act has authorized many diverse and important services and programs, including nutrition, employment, advocacy, and information and referral.

This series of workshops is dedicated to the late Senator Sparky Matsunaga. This is the second in the series of informal workshops to examine whether the OAA remains appropriate for the needs of the elderly in the 1990's.

This workshop considered two important topics for the reauthorization of the Act: information and referral programs and information flow within the aging network. A separate panel of experts addressed each of these topics in turn. An informal discussion between the speakers and the audience followed each panel's presentations. The following summary describes the workshop proceedings, tracing questions raised, issues discussed, and options proposed for amending the OAA.

PANEL I: INFORMATION AND REFERRAL

MODERATOR'S OPENING REMARKS

Mr. James Solomon, Senior Assistant Director, Program Evaluation and Methodology Division, U.S. General Accounting Office. (pp. 210-211)

This second workshop will examine two topics:

1. Information and referral services ("I&R"), and
2. Information flow within the aging network.

Each topic will be addressed by a separate panel of experts. As with the first workshop, the goal of this informal discussion is to raise important questions and to propose legislative options for responding to key issues that may merit particular attention in the 1991 reauthorization.

I&R, also known as information and assistance (I&A), is a core service provided under the OAA. This service may include information giving, needs assessment, service referral, client advocacy and education. Our first panel consists of representatives from successful programs across the country who will touch upon the following points: (1) A brief description of his or her program; (2) unique aspects of the program; (3) factors contributing to the program's success; and (4) legislative recommendations for the improvement of information and service delivery. (p. 210)

A second panel of experts will examine ways to improve information flow within the OAA. The concept of information flow refers to the information links between various elements of an extensive national aging network, including the collection and dissemination of data produced by the network. The aging network is comprised of the Federal Administration on Aging with its 10 regional offices, 57 State agencies on aging, 672 area agencies on aging, and tens of thousands of service providers. (p. 210)

PANELIST PRESENTATIONS

Mr. Mohamed Al-Ibrahim, M.D., Associate Professor and Head of Division of General Internal Medicine, University of Maryland School of Medicine, Baltimore, MD. (pp. 212–215; prepared statement) (pp. 216–223)

Topic: The Waxter Center for Senior Citizens.

This presentation will address three areas:

A. Description of a medical model program, the Waxter Medical Services Center, where academic and private groups work with local agencies in the planning and provision of services and education for the elderly.

B. Description of the unique aspects of this program.

C. Description of a legislative proposal to encourage area agencies on aging and private sector partnerships, and to support the development of an information system that would link agencies with acute care hospitals.

A. Description of the Waxter Medical Services Center (pp. 213–215; 217–218)

The Waxter Center, operated and supervised by the local area agency on aging, Baltimore City Commission on Aging and Retirement Education, is funded by Federal, State, and city agencies and by private donations. The services and programs provided by the Center integrate the University School of Medicine with five other professional schools (nursing, law, social work, dentistry, and pharmacy) which provide faculty and in-kind services. A relationship between the University of Maryland at Baltimore (UMAB) and the Waxter Center began in 1977, UMAB was awarded a 6-year contract to develop the geriatric Federal Area Health Education Center Program (AHEC).

Since 1977, the Waxter/UMAB partnership has become one of the largest and most successful geriatric AHEC programs in the State. Today, the Medical Services Program at the Waxter Center constitutes the ambulatory geriatric program at the UMAB. Waxter Medical Services is a full-time, comprehensive medical and educational program, providing medical, dental, psychiatric, and podiatry services.

B. Unique Aspects of the Program (pp. 214–215; 218–222)

Waxter Medical Services are under the direction of the UMAB Department of Medicine. The program makes available the following services:

1. A wide array of screening and preventive activities, extending to the outreach sites.
2. An interdisciplinary, comprehensive geriatric assessment program to serve the frail elderly.

3. A private practice where over 100 persons receive continuing care and 24-hour physician coverage.

4. Physician house call services and specialty consultation services on topics such as arthritis, gastroenterology, and clinical pharmacy.

5. Arrangements with local pharmacies to provide special services such as home delivery and drug education.

6. Education programs for clients and consumers through health fairs, lectures, etc.

7. Maintenance of linkages with legal counsel.

8. Provision of inpatient care for the program's patients at several hospitals.

    (a) A formal, interdisciplinary discharge planning process reviews all medical patients at University Hospital. The development of a satisfactory patient care plan at discharge has become increasingly difficult. Hospital stays are shorter, illness severity at time of discharge is greater, and the complexity of home care has increased.

The Waxter Center is a model educational site and the Waxter Ceriatric AHEC has realized its major goals and objectives. Despite this success, there remain a number of problems that need to be addressed:

1. Budget constraints in the city of Baltimore have resulted in cutbacks in the contractual agreement with Waxter Medical Services, threatening the viability of many services now available.

2. The private practice service has not been profitable. It is a labor intensive, primary care practice for a large population of frail elderly. Screening and preventive activities greatly exceed those specified in the contract with the city.

3. The geriatric assessment program and house call service always operate at a financial loss.

4. Inadequate information linkages with acute care hospitals—where patients at risk are often identified—hampers patient care. Hospital discharge planners must be linked with agencies and case managers to assure optimal discharge planning.

    (a) The Maryland program for geriatrics and gerontology education and research (GGEAR) has been working with area agencies (AAAs) and the UMAB for the last 3 years to compile and maintain a list of all geriatric resources and services which will be made available to the AAAs on a county basis. There are no current plans to link the system to hospitals or other clinical sites.

C. Legislative Proposal (pp. 214–215; 221–223)

This model of long-term care provides integrated and continuous patient care through the development of the relationships described above and through the informal linkages between a group of providers who share a common academic base. An unplanned hospitalization or some other unexpected health cost removes a client from this system and the essential continuity of service provision is broken. The following recommendations could address this problem.

1. Specific funds should be set aside for joint ventures between the AAA's and the private sector for program development.

2. Support and funding should be authorized for demonstration projects that would improve information transfer through a database of medical, sociological, and functional client information. This database should link health providers with available community resources for the elderly.

   (a) This proposed information system would assist resource and patient tracking, reduce duplication of resources, and minimize fragmentation of care. The system must address clinical issues such as which elderly groups must be targeted, and technical questions such as what information is to be collected and where will it be stored.

   (b) The system must also address legal issues (e.g., who will access the information and how will privacy be protected?, etc.).

3. The acute-care hospital should be the point of entry for the target group—the frail elderly. The indicators for "frailty" are yet to be defined.

   (a) The data available on the annual flow of elderly through the health care system indicates that the hospitalized frail elderly need comprehensive, interdisciplinary assessment while hospitalized. But this valuable assessment is not available to the community provider once the patient is discharged.

   (b) If acute-care hospitals were linked to the AAAs, they would have access to the I&R network, improving discharge planning and affording hospitals access to case management.

   (c) After discharge, the allocation of resources will proceed more efficiently, particularly important in light of the increasing number of traditional caregivers (children, spouses, etc.) entering the job market.

4. The system, once in place, should be validated through research showing that it results in continuity of care to the frail elderly.

Ms. Sue Boyd, Vice President of Community Services, Mile High United Way, Denver, CO. (pp. 224–226; prepared statement pp. 227–228)

Topic: The ElderInfoNet System.

A. Background of the ElderInfoNet System (pp. 224, 226)

The program was instituted 3 years ago to improve senior citizens access to information about social and health services, a key problem in the Metro Denver area. The AAA convened a consortium of service providers in the Denver area to design an eight county I&R network now known as ElderInfoNet.

The consortium selected Mile High United Way ("MHUM") as the systems manager for implementation of the I&R program. The MHUW already operated the region's most comprehensive I&R service, maintaining the area's largest service database and permitting access by many other I&R providers.

B. Unique Aspects of the Program (pp. 224–226; 228)

ElderInfoNet has several key components:

1. An integrated, automated database maintained by a consortium of nonprofit and government agencies through a contractual arrangement with MHUW.
    (a) The database was intended to address the problem of duplicative efforts to maintain information. Also, the goal was to create a larger, more comprehensive database which could be accessible to more service providers.
2. A telephone network which includes all of the agencies in the consortium and allows persons seeking services to enter the I&R network at any point and be transferred directly to other service providers or I&R services.
3. I&R training for all members of this system to improve utilization of the program by service providers.
4. A major public relations plan, under the direction of the AAA in Metro Denver, designed to increase public awareness of the I&R program.
5. Compilation of additional data from all service providers through the computerized database and referral system in order to overcome inconsistent and inadequate data.
6. A public/private partnership which relies upon member agencies to serve as active advisors.
7. The longevity of the consortium (2 years) despite the notorious reputation for disagreement among the aging services in the Metro Denver area.
8. The inexpensive PC-based network, built on software known as Community Service Locator.
9. Additional public/private partnerships evolving as the project is implemented.

The program will serve as a pilot project for application to other service areas. Although the program is not up and running yet, a public marketing plan will be in place by late 1990 and the database will be available to other service providers by 1991.

C. Reauthorization Issues (pp. 224; 225–226)

The following are the unanswered questions that need to be addressed during the reauthorization process:

1. How can the elderly public be contacted through small community agencies and outreach?
    (a) Small community agencies with the greatest potential to reach low-income and minority aging populations frequently lack the resources to participate in sophisticated I&R systems.
    (b) Who should meet this need and how should it be funded?
2. How have competing national efforts to manage workplace contracts (for elder care) affected implementation of this project?
    (a) Although local agencies are driven by the revenues generated by such contracts, do they interfere with the efforts of local projects like this?

Mr. Robert Logan, Executive Director, Council on Aging of the Cincinnati Area. (pp. 229–231; prepared statement pp. 232–238)
Topic: Living-At-Home/Care Coordination System.

A. Description of the Living-At-Home/Care Coordination System (pp. 113–117; 120–122; 226–230; 232–238)

The Living-At-Home/Care Coordination System (LAH/CCS) operates on the principle of one-stop shopping. In order to maximize efficient use of limited resources, careful screening of individuals seeking assistance is essential. Some clients simply need information while others need assistance contacting service providers and still others need a comprehensive package of services. The LAH/CCS is an easily accessible system which supplies information, assistance, and referral to case management. (pp. 231–232)

The entry point of this computerized care system, featuring a daily updated information database, is the I&R system located at the Council on Aging, which is the Cincinnati AAA. There are 19 community social service agencies connected to this I&R system through telecommunications. The AAA and these satellites can make referrals to one another through access to the common information bank. This system ensures follow-up and coordination—75 percent of the I&R calls can be satisfied by conveying information; the other 25 percent need follow-up or further assistance.

The system works as follows: (pp. 233–235)

1. Clients receiving long-term care services enter the system through a member provider agency.
2. All provider agencies can access the client information and thereby determine whether any other member agencies serve the client.
3. A universal assessment procedure is in place to determine a client's eligibility to receive services.
4. Eligibility is based upon inability to perform one or more Activities of Daily Living (ADLs) without assistance: ambulation, bathing, dressing, eating, grooming, and medication management.
5. An agency servicing an individual inputs their client's assessment into the computer and updates it every 6 months. Any other agency subsequently contacted by the same client can check the computer to see if the client receives services from another agency in the county, though it cannot access the details of the client's assessment.
6. The next step in the program's evolution will be to link hospitals into the system for a monthly service charge to defray most of the operating costs.

B. Objectives of the Program (p. 236)

1. To provide updated information to client and service providers.
2. To coordinate scarce resources.
3. To provide a system that will enable all agencies to use the same assessment program.
4. To obtain the available information for care planning purposes. The system recognizes the one-point entry system, but

will afford clients access to their community agencies for assistance.

C. Legislative Recommendations (pp. 231; 236)

1. All I&R systems funded under the OAA should have a system set up for follow-up on emergency referrals.
2. Additional money should be authorized to assist setting up such a system.
3. Assessments of clients should be required before long-term care services are provided.

Mr. Richard Sugiyama, Director of the Seattle-King County Area Agency on Aging. (pp. 239–242; prepared statement pp. 243–247; program description pp. 248–254)

Topic: Information and Assistance/Case Management System. (I&A/CM).

A. Description of the Program Information and Assistance/Case Management System (pp. 239–240; 243–245)

The Seattle I&A system is intimately tied to its case management services. The I&A system, formally implemented in 1984, is a single intake system, but with multiple points of entry to provide access to a racially and ethnically diverse client population. The functions are to provide telephone information to callers, to provide assistance by phone for those persons who cannot access services themselves, and to screen those clients who require a more intensive, in-home assessment by case management.

The I&A system consists of five subcontracted agency providers in King County: one primary I&A program and four special I&A providers. The former provides services to mainly English-speaking persons while the latter agencies help to lessen the barriers of language, culture, and geographic isolation for the non-English-speaking client communities.

Persons entering the system through any of these five agencies gain access to a wide array of community services (e.g., home-delivered meals, health care, housing options, etc.). Individuals entering the system through special I&A programs require more extensive intervention. They are screened and then referred to an agency for services. A comprehensive assessment of the client by a case manager follows within 3 days.

The King County Case Management system consists of one large program with two smaller geographically based programs. Case Management services provide five functions:

(1) in-home comprehensive assessments;
(2) written individualized plans of care;
(3) implementation/coordination of the service plan;
(4) ongoing monthly monitoring and at least four in-home reassessment visits during the first year; and
(5) client termination planning.

B. Unique Aspects of the Program (pp. 240–241; 245)

1. A system that recognizes cultural diversity, linguistic obstacles, and geographical barriers, and addresses them with culturally relevant services.

2. A system which emphasizes a range of service levels and focuses on the least restrictive care options, along with client choice.

3. A free-standing system, separate from any other service provider, allowing for a greater degree of objectivity and an opportunity for client choice.

4. A system which coordinates with minority community organizations to provide culturally relevant services.

5. A system which utilizes gatekeeper training in order to inform community and local service providers about warning signs that may identify at-risk elders.

6. A standardized system of forms, data collection, and service referral for the five I&A programs and the three case management programs.

C. Factors Contributing to the Program's Success (pp. 241–242; 245–246)

1. The current system evolved from an earlier one established in the mid-1970's and built around the congregate nutrition sites.

2. In the early 1980's, the SSA and local AAA developed a targeting policy that allocated the State's declining resources to the most vulnerable persons in the community.

3. In 1983, the AAA developed a case management program policy that emphasized a coordinated I&A and Case Management system.

4. The State, recognizing the difficulty in providing services to minorities and others, created a weighted formula that allocates aging funds based upon the targeting characteristics.

5. The AAA set higher expectations for serving minorities because of the high incidence of poverty among minorities.

6. The pre-existence of minority agencies with which to subcontract helped establish the AAA case management program.

7. A partnership exists with the community to secure Community Development Block Grants (CDBG) for Chinese Information Systems.

D. Legislative Recommendations (pp. 242; 246–247)

1. Revise the language in the OAA to allow AAAs to provide I&A services and to avoid having each AAA seek a waiver from the State if it wants to provide such services in-house.

2. Create coordinated I&A and case management services at the State level as a regular component of the AAAs ongoing services.

PARTICIPATION FROM THE AUDIENCE

Senator David Pryor. Millions of older people are unaware of services that are available to them. Moreover, the elderly are somewhat reluctant to come forward and admit that they do not know where to find a particular service. (p. 255)

The Aging Network has no more important mission than to provide elderly persons and their caregivers a place to turn for information. It seems to me that the Aging Network must take a more aggressive approach in assuring that elderly Americans are aware of available services and obtain information that is most useful to them. (p. 258)

Consequently, communication and dissemination of information within the network must be improved. On this topic of information flow, I believe there are two critical issues: (1) what types of information and data should be collected? and (2) how should that information be shared with other interested parties? (p. 258)

Ms. **Sheila Manheimer** [National Council of Senior Citizens]. The language of the original Act in 1946 underscored the importance of outreach. Today, outreach is practically ignored in the Act. Discussions of long-term care and access refer to those persons who call in to the network. The topic of outreach should be re-examined as a valuable means of cutting costs.

Will the Act accurately address the two primary benefits of outreach to targeted communities—first, to provide services that will decrease costs, and second, to evaluate needs so that people do not become frail elderly? These various models seem good in theory, but what costs do they entail? (p. 259)

Mr. **Walter LaMendola** [designer of ElderInfoNet]. The element of public access is designed into the Denver project. The database for the project operates on the major library systems in the metropolitan area. Through the Colorado Alliance of Research Libraries, an elderly person can actually access all the available services.

In addition, there is a very active Senior Net group in Colorado Springs. The library system there has not only I&R data but also schedules of activities and programs operating in different senior centers. (pp. 259–260)

Mr. **Sugiyama**. The switch to case management from outreach left a gap in the continuum of care. Although the switch was necessary at the time, now the process of backfilling is under way. A number of programs, like a nutrition outreach program, utilize an outreach worker. Computers alone cannot properly fill the gap that currently exists because computers cannot always be accessed.

In addition to personal outreach, the provision of trained volunteers at senior service centers has facilitated outreach efforts, but has created problems such as confidentiality, etc. A third effort at outreach involves a partnership with AARP to have AARP-trained persons work at some of our area senior centers.

ElderInfoNet now works closely with Blue Cross, providing case management services for Blue Cross enrollees. This new direction may become a trend in California as well. (p. 260)

Ms. **Boyd**. All of these models for information networks are intended to address the professional user of the available information. But this information needs to translate into the existing outreach efforts. Small community agencies are better equipped to do this outreach than bigger agencies involved in I&R. (pp. 260–261)

Mr. **Solomon**. The issue of cost is as important as the issue of outreach. Some of the services need to be scaled down because of the cost of funding these services. What would be the effect of these cut-backs and trade-offs between services and money? (p. 261)

Mr. **Logan**. The maintenance and up-keep costs of computerized information systems surprise those who see computerization as a solution to the administrative problems of information networks. One way to help defray costs is to include hospitals that want to be part of the system, that want information, and that are willing to pay for the information. (p. 261)

Dr. AL-IBRAHIM. Screening and preventive programs cost money up front. However, as the medical model suggests, the cost of failing to fund these programs is even greater in the long run. Hospitals do want to network into the system. There are many resources available, but start-up funds are required to put the demonstration programs in place. (p. 261)

Mr. SUGIYAMA. One of the King County programs is actually located in a hospital setting. The case management programs still maintains a social service model, one which identifies those persons with chronic health care and social service needs. In an effort to develop a service plan, the current program reduces the amount of re-hospitalization and subsequent nursing home placement. (pp. 261-262)

Ms. BOYD. The design of the model in Denver was intentionally selected to be a low-cost one. There are two dimensions: (1) use of PC hardware and software; and (2) in-kind contributions from agencies which are already involved in I&R and which already have resources committed to this kind of project. It is a matter of shifting existing resources rather than investing totally new resources. (p. 262)

Dr. DEBRA WERTHEIMER [Waxter Medical Services]. First, access and outreach are critical. The I&R services cannot wait for persons to come to them. A large segment of the population do not know how to access the system or are afraid to access the system. A goal should be to identify at-risk persons before they become sick or develop social problems, bring them in to the system and provide them with available services for which they are eligible. (p. 262)

Hospitals and emergency rooms provide entry points where many elderly, before they become frail, enter the system. If the available resources are not linked to hospitals, then the desired population will never be captured by the network. Other novel methods of accessing people should be developed without creating new bureaucracies. Hospitals, which want to enter the system, are one such method. (p. 262)

Second, once persons are identified as frail and linked to these systems, then premature nursing placements, recidivism, and functional impairment can be prevented. Full utilization of existing resources can aid this effort. The increased use of rehabilitation centers permits more people to re-enter the community. Occupational and physical therapy in the hospitals increases an elderly person's functional level upon discharge, the point at which they can be linked into services. In short, the medical and social networks must be brought into a working relationship which links the resources available within each network. (pp. 262-263)

Senator PRYOR. In discussing the accessibility and commitment of hospitals to be involved in the Aging Network, are we referring only to large metropolitan hospitals? We should also consider possible roles for smaller rural hospitals, some of which have only 50 or 60 beds. (p. 263)

Dr. WERTHEIMER. The medical network includes small community hospitals as well as large metropolitan hospitals. Many hospitals are identifying the elderly as the population they will be serving over the next several decades. They are creating an array of services to identify those in this targeted group. Hospitals of every size are interested in developing senior outreach programs, but the large hospitals are likely to be the most resistent to developing access programs for the elderly. (p. 263)

Mr. **Sugiyama**. Hospitals in King County play an important role in referring persons to the current I&A system because most of the major hospitals operate senior care programs.

We should emphasize a gatekeeper-type program which focuses upon people, other than aging network personnel, who come into contact with the elderly. Spokane, WA, has an innovative national model which includes extensive training with postal delivery persons. The goal is to get people into the I&A system before they get to the hospital. (p. 263)

Ms. **Boyd**. Seniors access information and services from a variety of points. Hospitals are only one entry point. Once the integrated database in the Denver model is developed, it will be available to other service providers that have client contact, including hospitals. (p. 264)

Mr. **LaMendola**. A study of the tertiary hospitals in Colorado revealed that elderly frequently come to the metro area for procedures that rural hospitals cannot handle. These hospitals almost never refer any information about the after care plan back to the rural service provider. The net result is that an elderly person from a rural area who visits an urban area for care leaves in a much worse situation than the person who lives in the metro area and simply returns home after receiving care.

One solution to this problem is to design a computer format that can be shared through the entire State in an economical manner. This would allow rural hospitals and tertiary care centers to communicate regarding after-care programs. (p. 264)

Dr. **Wertheimer**. Hospitals probably do not refer back an after-care plan because they have not developed very efficient after-care plans. Physicians, hospitals, and all the health care providers do not think about an effective method for discharge planning. If they do not consider discharge planning, they cannot offer an after-care plan. The providers must be educated, not simply those persons involved in I&R. Absent such education, no effective after-care plan can be developed. Even a very extensive after-care plan will be ineffective if it relies upon people who are not very educated or attuned to the needs of the elderly. (p. 264)

Mr. **LaMendola**. In the Colorado project, a tertiary care center operates on the same software as the ElderInfoNet program. After-care planning data and resources in both the metro and rural areas can be shared. It was only a small part of the problem that the tertiary care facility was not doing the discharge planning. In fact, it was performing discharge planning, but it was not communicating that to anyone. (p. 264)

Dr. **Wertheimer**. The tertiary care facility may be doing the discharging, but it often has no plan for discharge and it certainly does not communicate that plan to anyone. (p. 264)

Dr. **Al-Ibrahim**. The systems proposed for developing uniform or universal assessment formats at the I&R level need to be done at the hospital level as well. Whether it be tertiary care or rural care, mechanisms must be developed that would also educate those individuals doing the discharge planning. The information network is the second step which links them together.

Rural hospitals and small community hospitals in urban areas have important roles to play. Many have developed extremely good linkages with local agencies and with chronic care institutions. They have developed outreach and home-care programs and are probably much more interested than the tertiary care centers who are involved in high-tech, high profile programs. (p. 265)

Ms. MARY SCHNEIDER [Staff Member for Senator Pressler]. There is a marked difference between the outcome of persons in community-based services and those in nursing homes. Do the proposed systems include a way of tracking those persons in community services that are disabled in their activities of daily living? Are these people tracked to see how long they stay in community-based services and to determine what factors are important to keeping them there, as opposed to transferring them to an institutionalized setting such as a nursing home? (p. 265)

Mr. LOGAN. In Hamilton County, OH, people can be tracked for the first time through the Living at Home Program. Also, the 2176 Waiver Program diverts Medicaid funds from nursing homes into programs designed to keep people in their own homes. Now, the data can be compiled and analyzed in the ways Ms. Schneider suggested. (p. 265)

Dr. WERTHEIMER. With respect to discharge planning, special attention is paid to the frail elderly. There are almost no data about discharge planning and about how to prevent persons from returning to the hospital. Some data have been collected regarding those persons who are at-risk for rehospitalization. The older people who are living alone and have multiple problems with activities of daily living are primarily people with no support systems in the community. (pp. 265–266)

But plans to prevent hospitalization and models for dealing with persons who have been hospitalized have not been developed. The outcome data needed are very difficult to access. The numbers of hospitalizations, length of stay, nursing home readmissions, and use of community resources are almost impossible to track at the present time. Tracking should improve as Medicare has begun to merge Part A and Part B files, but for now there is no way to track the necessary information. (p. 266)

Mr. LAMENDOLA. Technology is not the solution to the access issue. The stress on technology should not denigrate the importance of aggressive outreach by trained personnel. Although the public library program in Denver is access through technology, it will also serve to train all the librarians in needed skills such as critical listening, dealing with seniors who visit small public libraries, talking with them about problems, and accessing by telephone the resources that seniors need. (p. 266)

In addition, the project includes the provision of these services to the police, all local agencies at the point at which they deal with the public, and all the parks and recreation facilities. Not all of this has been accomplished yet, but there are even plans to extend the program to senior highrises where trained staff would discuss with the elderly the problems they face. (p. 266)

Technology is simply the means to assist persons in accessing information about resources they did not know existed. Many older Americans actually access I&R services on their own. In so doing, these independent elderly draw upon the services that are available. Through technology, a shift may occur so that people who are active and independent can access I&R on their own while those in need of services can enter a different mode when they contact service providers. This does not mean that person-to-person outreach is not needed. Rather, technology can help solve part of the access problem. (p. 267)

Mr. **Logan**. Each of the different programs discussed are excellent for their respective communities. But, more generally, no system will work if the community does not develop and design it. The Cincinnati project works because the community was involved in the development of the assessment and the software. The community had a vested interest in the success of the program. The byproduct of this cooperation between the different social agencies in the community is the Living-at-Home/Care Coordination System. (p. 267)

Mr. **Solomon**. When the OAA programs first got underway in the late 1960's and early 1970's, emphasis was placed on more traditional I&R, i.e., providing I&R to older people about all possible services from bus schedules to health care. The proposed models suggest a shift in the emphasis of I&R and I&A toward health care and, more specifically, toward long-term care and case management. What does I&R mean in the Denver project?

In the reauthorization process, should I&R focus almost exclusively on health care or long-term care? Or, should there be an emphasis upon the development of specialized I&R systems like in Cincinnati that are ancillary to a broader community I&R? These same questions should be addressed by those persons within the aging network who assess the information needs of the elderly. Older people have difficult times accessing information regarding needs other than health care such as transportation, housing, and employment. (pp. 267–268)

Ms. **Rosalie S. Abrams** [Director of the Maryland State Office on Aging]. These questions, and many of the other concerns that have been voiced, are addressed by the models to be discussed by the second panel. (p. 268)

Ms. **Boyd**. The elderly need information on a wide spectrum of services. The vast amount of information gathered, and the specialization of that information, make meeting all of the elderly's needs very difficult.

The Denver model does call for a more traditional look at the information needs of seniors. Some of the more difficult needs to meet are very basic and often not in the health care arena. The information must be effectively integrated into a network so that health care information is not completely separate from more general pieces of information. (p. 268)

PANEL II: INFORMATION FLOW

MODERATOR'S OPENING REMARKS

Mr. SOLOMON. The second panel will address the efficacy of information flow within the aging network. Information flow refers to the data collected and provided to the network and the process by which this information is disseminated. The critical element of information flow is outreach to insure that the elderly know that services are available.

The first panelist, Mr. William Bechill, will provide the background regarding information flow, including a conceptual framework for information flow, the strengths and weaknesses of this system, and recommendations to improve information flow within the aging network. The panelists who follow will address the efficacy of the lines of communication, what types of data are required, how data currently collected is used, and additional information that could be provided to the network to improve AAA's operations. Also, they may address the issue of technical assistance, e.g., what is provided by the network and what should be provided. Finally, the panelists will offer proposals for reauthorization of the OAA.

PANELIST PRESENTATIONS

Mr. William Bechill, Associate Professor, School of Social Work and Community Planning, University of Maryland at Baltimore. (pp. 270-271)

Topic: Information Flow System Background.

A. Background of the System (p. 270)

First, the aging network consists of the Administration on Aging (AOA), various State units on aging (SUAs), the area offices on aging (AAAs), tribal organizations receiving funds under the OAA, and literally thousands of direct service providers at the local level. The network has also been subject to an increasing number of program priorities as a result of the "targeting strategy" developed under the OAA legislation. Independent initiatives undertaken by State and local governments on behalf of their elderly impose upon the State and local agencies a number of responsibilities in addition to those imposed by the OAA.

Second, there is a considerable amount of information flow, or information transmission, between various parts of the Aging Network. Much of the information is related to the reporting requirements and statistics that need to be collected with respect to the various mandates set out in Title III of the OAA. These very specific mandates are designed to identify the number of elderly served by various service categories and their demographic characteristics.

As a consequence of the 1987 reauthorization of the OAA, the AOA and the State agencies are now collecting data relative to the needs of the disabled elderly and other groups. The programmatic emphases built into Title III require AOA and the State agencies to collect data regarding the performance of senior center programs and supportive services such as congregate meals and the new inhome services program.

B. Legislative Recommendations (pp. 271-272)

1. Rather than focus on information flow, attention should be given to the information needs and demands of various segments of the aging network. Specifically, what kinds of reporting are vital to performing the mandates of national and State legislation? What kinds of national databases would best serve the various levels of the aging network? For example, a national databank relating to senior centers and senior center programs would assist programming efforts.

2. There is a need for a continuous manpower database to clearly identify personnel needs on a professional and paraprofessional basis.

3. No empirical study of the information flow, either its vertical or horizontal dimensions, has been conducted. Such a study is needed. Too much time is now devoted to generating information that may not be used and that may not be necessary.

4. In the area of technical assistance, Congress should take steps during the 1991 reauthorization to enhance the capability of both the AOA and the State agencies to provide technical assistance to the area agencies and to the direct service providers.

5. The AOA needs to be given support to get their staff out of the regional offices and into the State and local communities. There must be greater personal interaction with the State and area agencies.

6. The AOA and the State agencies should also have more qualified staff. The goal is to establish the AOA and the State agencies as sources of guidance and expertise for the entire aging field.

7. Finally, the aging network is not reaching a substantial number of low-income older people through existing efforts and programs. Outreach must be improved.

State Senator Rosalie S. Abrams, Director of the Maryland State Office on Aging. (pp. 272-275; prepared statement pp. 276-283)
Topic: SeniorReach Outreach Program.

A. Background of SeniorReach (pp. 273-274)

A major problem that cuts across all human service delivery systems is that everyone uses different definitions to describe different services and information. Much of the information acquired is the product of educated guesswork, such as identifying minorities who receive services. The information is inaccurate. Maryland works closely with the area agencies in developing formulas and trying to reach a consensus regarding data. (pp. 273-274; 276-277)

Another major problem is providing needed services when the clients are identified. Maryland's approach to outreach, a top priority of the AOA, rejects the medical model for providing services. Transportation, housing, and housekeeping needs cannot be assessed through the medical model. Abandoning the medical model would be a great service to the aging community.

Long-term care includes everything, not just health care. The aging network cuts across every possible kind of service. For example, transportation is one type of supportive service that everyone needs and that must be included in long-term care. Health care, or the medical model, is the end result of failing to provide those supportive services that people need to remain healthy and in the community. (pp. 274; 277)

SeniorReach, a consumer information activity, operates as a statewide information campaign under the Maryland SUA to enlist corporate, private, and public partners in efforts to increase public awareness of services and benefits available to older persons. SeniorReach provides a way to build coalitions with the private sector aimed, initially, at providing information and ultimately at increasing the availability of services. SeniorReach uses the existing communication systems of practically all major corporations in Maryland, including public utilities and private companies. (pp. 274–275; 279–280)

The SUA provides information, and the corporations use this information in communicating with their employees who are providing care to older people. Information provided by the SSA details services available in the community for use by employees, their families, and the elderly. Currently, the corporations are now providing this information, thereby becoming sources of available services for the SUA.

One of the most successful AAA efforts at providing information is the production of detailed consumer guides on topics of interest to the elderly, including Medicare, Medigap, and long-term care insurance. In collaboration with our Attorney General's office, the SUA produced booklets on specialized topics such as a guide to cutting health care costs and a guide to nursing homes.

To broaden the scope of this program, we are attempting to establish a relationship with the medical community, including every hospital in the area. Ideally, the SUA would provide information to doctors regarding available services. The doctors occupy key positions because they are generally the system's first contact with an older person. While they should know what the community has to offer, the doctors presently do not.

Once a need is identified and outreach is accomplished, the central problem still remains: is there money available to provide the necessary services? (p. 275)

B. Legislative Recommendations (pp. 282–283)

1. Each State should develop specific consumer guides for their own residents. Since decisions about aging services are increasingly being made at the State rather than the Federal level, State agencies are appropriate points for dissemination of consumer information. (p. 279)
2. The Census Bureau, the National Institute on Aging, the National Center for Health Statistics, and the AOA should collaborate to develop social indicators of unmet need and uniform definitions of key supportive services. (p. 273)
3. Uniform data collection is important where the network's effectiveness depends upon different agencies comparing information. Uniform assessment of need should begin by accurately identifying those in need in the community. (p. 274)
4. The types of information presently required by the Aging Network must be re-evaluated to decide if they are necessary, if they are actually being used, or if they are simply a waste of time and energy. Providing more and better information to AOA regional

staff would assist States in obtaining what they need more quickly and efficiently. (p. 282)

5. While it is not necessary for the AOA to require that each State have a formal organization of area agencies, it is essential that communication between the State and area agencies occurs regularly. (p. 283)

6. The Act should require improved and current State-specific data on the number of older individuals living at or below the federally defined poverty level income guidelines. (p. 283)

7. SUA staffs should be trained in the appropriate use of social indicators of unmet need and the application of uniform, standard definitions of supportive services. (p. 273)

8. Congress should require the AOA to strengthen its role in technical assistance, a key issue in information flow. The AOA staff should be able to provide on-going advice regarding implementation of the OAA. Increased travel allowances for AOA regional staff would allow program specialists to more frequently provide State office staff with direct, "hands on" technical assistance. Additional resources should be allocated for site visits to supplement written and telephone advice. (p. 281)

Ms. Cheryl Schramm, Chief of the Aging Services Division, Atlanta Regional Commission. (pp. 284–288; graphic handouts pp. 289–298)

Topic: Vertical and Horizontal Information Flow.

Four key points will be addressed:

1. Vertical Information Flow.
2. Horizontal Information Flow.
3. Distribution and Dissemination of Information.
4. Legislative Recommendations.

A. Vertical and Horizontal Information Flow (pp. 284–285)

In the vertical information system, the AOA is on top, with information then passing through the regional AOA office, and through the State to the AAA, the Atlanta Regional Commission ("ARC"). ARC then works with OAA providers and the elderly community. However, the role and responsibility of the aging network has gone far beyond merely working with programs or services funded by the OAA.

Information is received from many sources, but often it takes an inordinate amount of time to collect certain information and move it through the system. Often ARC is specifically required to gather certain information and move it back up the system to the AOA. Although much of the information needs to be collected, the process consumes time and resources that could be devoted to more pressing responsibilities.

Information flow is complicated by ARC's interaction with a network of Federal, State, and local organizations outside of the OAA system. ARC functions as the pivotal information point for many of these organizations, as well as for the AOA. ARC receives much of its information through publications from entities outside the Aging Network. ARC is currently developing relationships with the private sector in receiving and sharing information.

The ARC receives information from providers in the community at large, in addition to specific OAA providers. For example, the American Association of Retired Persons (AARP) provides an excellent source of information for the aging network. The other 670 AAAs across the Nation offer an invaluable source of information because many persons need information from other areas of the country.

B. Dissemination of Information (pp. 285-286)

Once information is received from these various sources, it is plugged into the ARC aging information system which has developed over the last 9 years out of a simple I&R system. At the center of this system is an Aging Resource Center, which includes a computerized provider base of 1,500 providers extending beyond the AAA's eight-country region. The Resource Center contains extensive demographic data, an Aging Information Library, and education and training information.

In addition, the Resource Center created program development packages in hope of fostering establishment of adult day care centers. Information packages with Health Department requirements, etc., are sent to those persons interested in turning their homes into a personal care home or an adult day care center.

The Resource Center provides funding information and resource development. Once representing 80 percent of many agencies' funding base, the OAA now accounts for only 40-50 percent of agency funding, as demands for OAA services grow while the money available through the system remains fixed. The Resource Center also stresses employment opportunities by maintaining résumés on file.

The Resource Center has three distinct divisions: (pp. 286; 295)

1. Aging Information Consultation and Referral,
2. Special Services, and
3. Education/Training.

The Aging Information Consultation and Referral Division includes the following components: (pp. 285-286; 295)

1. The Aging Connection—A public I&R system.
2. Work Family/The Partnership Group—Through specific contracts, the system serves national clients such as IBM, Mobil Oil, and other companies.
3. ACCESS—Through private funding, this same kind of employee information consultation system is established for local corporations.
4. Employment Hotline—Corporations submit listings of open positions that are made available to interested older persons.
5. Registries of Individuals—People accessing the system can locate individuals who might be able to provide a particular service.

Under the Special Services branch, the Resource Center is moving in the direction of working with developers, students, media, and other groups, such as elected officials and doctors, which seek information and can assist in dissemination of information regarding aging programs throughout the community. The goal is to provide these people with information concerning the elderly that can be distributed to persons whom they contact in their professional capacities.

In Education and Training, the Resource Center provides training to provider staff and employees of member corporations. The training, which covers a wide array of information, can occur at the particular worksite or at the Resource Center. (p. 287)

A critical role of the Resource Center is its relationship with local churches through development of a resource guide and establishment of a seminar series. The center trains lay persons or church staff to be I&R specialists within their churches. (p. 287)

In addition, the center created a calendar which includes a final page describing ARC and the means for accessing information. Simply, our goal is to find new and creative ways to distribute information.

ARC moves a great deal of information down to the county level. ARC provides Title III money so that each county-based aging program has an I&R staff and a number of case managers. In the county organization, an older person need only access one number to enter the whole service system within his or her particular county. (p. 287)

AAA Information Distribution includes special outreach through activities such as media specials and information fairs. The system is set up not only to give information to those who access it but also to go out and actively provide it. Briefings, training, and a 24-hour hotline assist ARC's effort to reach out to the elderly that are entitled to benefits but have not received those benefits, as well as to provide the important information regarding available services.

C. Legislative Recommendations (pp. 288; 299)

1. The Act needs to contain language that accurately reflects AoA's responsibilities in providing technical assistance beyond the OAA network and in relating to other Federal levels. Specifically, the Act should reflect the AAA's movement into long-term care and in the development of private pay systems.

2. The Act needs to develop service standards to assure that listed providers follow certain guidelines in providing the wider array of services now available through the network.

3. SUAs need to be much more active in communicating with AAAs so that before a service provider is made available to the public, SUAs will have a more comprehensive understanding of exactly what can be expected of particular services provided through the AAAs. Then the AAA can define the specific details of particular services so that potential clients will better understand what benefits they will be receiving.

4. The AAAs need to develop a working partnership with each other, as opposed to the current adversarial relationship. If the AAAs work together rather than compete against each other, both vertical and horizontal information flow regarding available services will improve. The aging network should include additional AOA regional offices and should build upon the AAAs already solid relationship with SUAs.

Mr. James Loftis, Executive Director, Services and Opportunities for Seniors of North Little Rock, AR. (pp. 300–302)

Topic: Services and Opportunities for Seniors.

A. Description of the Services and Opportunities for Seniors

With current funding levels, agencies such as Services and Opportunities for Seniors ("SOS") must be careful not to increase demands for service beyond their ability to provide these services.

In terms of information dissemination techniques utilized to reach potential service participants, word of mouth continues to be the most effective outreach tool. In addition, the cultivation of relationships with area hospital discharge planners and home health agencies has proven to be an effective way to reach the homebound elderly. Service brochures and community-oriented speaking engagements, especially in churches, aid more in volunteer recruitment and fundraising than in accessing potential clients. Although special events are advertised, mass media have never been used for client recruitment. (pp. 300–301)

All Title III service providers in Arkansas participate in a management information system that seeks to standardize demographic information collected by service providers and to enable automization of service reporting and billing. The system further allows central office tracking of a client through any particular service throughout the State. This system affords the agency the opportunity to reallocate the money once used for administrative costs back into services.

Also, service costs must be tracked. Data collected are used to bill various funding sources for reimbursement. The demographic information which is collected allows for the measurement of progress toward providing services to targeted groups such as minorities and those with the greatest social and economic need. (p. 301)

B. Legislative Recommendations (pp. 301–302)

1. The value of collecting cost information is self-evident, given the limited resources available to the agency. But additional information must also be collected. Specifically, there is a need for objective needs assessments, tied neither to currently available services nor to anticipated service development. True longitudinal information should also be obtained to measure the actual impact of current services. (p. 301)

2. The aging network should assist service providers by offering information on effective cost-containment practices, as well as alternative funding sources. Such information would aid the reestablishment of partnerships between State units, AAAs and providers that existed before the requirement for competitive bidding for service contracts. (p. 301)

3. The aging network must take steps to minimize the adversarial component of contracting. No competitive bidding exists in this program because the tremendous capital expenditure necessary to develop and operate an aging program prohibits an infusion of new bidders. The competitive bidding process precludes an AAA from effectively providing information necessary to develop a new service provider. Competitive bidding makes adversaries out of agencies which need to be cooperating. Competitive bidding also discourages cooperation between existing service providers. An atmosphere of

mistrust emerges when an existing provider bids on another provider's contract. With the emphasis on unit cost in competitive bidding, an adversarial relationship between the area agencies and providers is further augmented. (pp. 301–302)

4. The underfunding of aging programs has forced providers to become both managers and fundraisers. The aging network must fight to maintain existing funding, while seeking alternative funding for services. Congress must recognize the need for increased appropriations for aging programs as both the elderly population and the demand for services increases. (p. 302)

5. Free flow of information between the levels of the aging network requires the different levels to work together as partners. Through the reauthorization process, Congress has the power to remove the obstacles to these partnerships. (p. 302)

PARTICIPATION FROM THE AUDIENCE

Mr. Solomon. First, not enough information flows between SUAs and AAAs. Vertical and horizontal information flow must be improved. Second, so much information is collected by the aging network that the quality of the information is not being properly assessed. How can the necessary information be distinguished from the unnecessary information? How can the information flow level of assessed to assure that it is the right level? (p. 302)

Mr. Loftis. All the different kinds of information that the Aging Network is required to collect is useful information. Much of the information collection, such as the demographic information, is used. Microcomputers allow for greater manipulation of this data to serve a variety of purposes. (p. 302)

Ms. Abrams. The critical data needed is demographic information. Between 1990 and 2005, the number of persons over 85 will double. Such data are useful to assess service needs and to assess costs. Costs have risen 18 percent within the last year because the needs are greater as the population of elderly and handicapped increases.

As data are collected, attention must be paid to what kind of data is gathered and how much time is spent collecting it. A critical issue is whether the collected information is actually being used. No one evaluates what happens to the information after it has been collected. Much of the information still being collected may have been useful 10 years ago, but is unnecessary today. (pp. 302–303)

Mr. Solomon. The OAA, which once provided the network with 80 percent of its funding, now provides merely 40 percent. Many of the presentations have discussed different funding sources and the different points at which the aging network seeks to integrate various organizations. This emphasis upon alternative sources of funding and support reflects the new reality that the OAA is no longer in the driver's seat. Should the Act be changed to reflect its new role as a part of the overall aging network rather than its leader? (p. 303)

Mr. Bechill. If the Act has a sunset provision, such that the OAA would be terminated as of next year, what would be the consequences? This scenario underscores the role that the Federal Government should have in this field.

The Act should not be eliminated. In Howard County, the Act represents only 21 percent of the total budget in the aging field. The movement away from the Act is a product of the momentum generated by the Act over the years. The Act has prompted the local leadership and private citizens to make the aging field a priority. (p. 303)

Of greatest concern should be the level-funding of the Act over the last 7 or 8 years in the face of a growing elderly population. The demographics of the aging field reveals that the Federal Government has not kept pace in recent years. Should there be Federal responsibility? What should that responsibility be? Is a strong national program with a highly visible AOA desired? What other alternatives would be preferred? Certainly the existence of the OAA and the AOA over the last 25 years has changed the aging field considerably. But experts in this field need to address these issues. (pp. 303–304)

Ms. **Schramm**. The OAA provided the base which made all subsequent progress possible. The talk of additional money coming into the system is only possible because the OAA provided the core funding. County government's partnership with the private sector is simply building upon the OAA base. The private sector's provision of home-delivered meals and homemaker services does not represent a new direction.

But the Federal Government should make more use of the structure set up by the OAA with SUAs and AAAs. Why should the Social Security Administration set up a different system? The State offices and AAAs should be the focal points for disseminating information regarding available services. No other service has developed such a national network. The network needs to be strengthened through the reauthorization process, but it now allows for State offices and AAAs to communicate with each other and for people to access information outside their own area. (p. 304)

Ms. **Abrams**. One of the great strengths of Maryland's program is cooperation between the State Office on Aging and other human service delivery departments. This cooperation took time and required staff to overcome their territorialism. Hopefully, the success of the Aging Network can serve as an example.

The interagency committee established in Maryland has been extended to include the Secretary of Transportation and the Secretary of Housing and Community Development. Job retraining and employment for older people is central to making older years productive ones and to meeting the labor needs of the country. (p. 304)

The Maryland network has set a standard for delivery of services to the community in a way that other generic services have not done. Other services are driven by targeted populations and by funding sources, among other things. The Maryland network delivers services based on the needs of individuals. The focus is on the individual receiving the services and not the category of services received.

For example, the problem with the medical model is that it employs people who are not directly involved with the service itself and therefore cannot identify specific service needs. Doctors and nurses are skilled providers of health care, but that is not always the need of an elder person. The OAA has been a lightning rod to identify and provide these other critical services. (p. 305)

Mr. SUGIYAMA. In Washington State, the aging network under the OAA serves as a model for the other human service programs. No other program is as comprehensive as the OAA in terms of policy development, planning, service coordination, education, and service delivery. (p. 305)

Dr. AL-IBRAHIM. Certainly there are other issues than health care that need to be addressed. It is true that many doctors are ignorant and obstinate, but doctors are also the system's first contact for needy clients. Doctors can make the difference in a successful referral. Hospitals are of special interest because they see a high volume of seniors, because they identify the highest users of all kinds of resources, and because they are the training place for future physicians and health providers.

For these reasons, the medical mode should not be excluded from the network. When people experienced sudden deterioration, the so-called "slippery slope," health care and social needs become intertwined.

Finally, much has been said about process, but little about outcome. Models should be evaluated and validated in terms of outcomes on a model-by-model basis to see what works. (pp. 305–306)

Mr. SOLOMON. The medical model is part of the aging network. Ms. Abrams merely pointed out that it is not the only part. (p. 306)

Ms. PEGGY SHEELER. Family and Children's Services of Central Maryland. The State units and the area agencies have so successfully found a way to meet the need through outside resources that level-funding seemed the wise legislative course. But, more emphasis should now be placed on raising current funding levels. No further services should be added if the funds are not going to be available to pay for it. (p. 306)

Ms. ABRAMS. One of the provisions of Title III is in-home services. The State of Maryland receives $75,000 which pays for 5–8 people. But, Maryland has over 2,000 people who coordinate community care. Maryland provides the balance of necessary money, approximately $5 million.

About 30,000 people need in-home services paid for by the public. This amounts to a need of approximately $75 million for publicly funded services in Maryland. This is for long-term care to keep people in the community so they do not have to enter nursing homes. Such services may cost $300 a month now, but it will save $3,000 a month in nursing home costs later. The OAA must allow the network not simply to do some of the minimal tasks, but to also meet some of the real needs that currently exist. (p. 306)

Mr. BECHILL. Many are rightfully concerned with the recent trend to "medicalize" the OAA programs. The debate regarding programming at both Federal and State levels centers around issues like long-term care. This should not be the primary mission of the OAA. (pp. 306–307)

The Act has been used to address problems that should be dealt with elsewhere. Although the OAA can be interested in long-term care, the emphasis should be upon returning to more general and preventive kinds of services. If Congress is serious about giving this program major responsibility for the large-scale, community-based, long-term care services discussed in this workshop, then the appropriations for the Act will have to be tripled and perhaps quadrupled. That is simply not going to happen because of the way the legislation is financed.

This issue of long-term care ought to be debated in the same fora as Medicare and Medicaid. Long-term care will not be provided through the OAA unless Congress decides to do so and gives enough money to do so effectively. (p. 307)

Ms. **Schramm**. The OAA network has been underfunded for a number of years. Additional public funding must be sought, and strong consideration must be given to private pay. Thousands of persons who need home-delivered meals and other home-delivered services can afford to pay for them and want to pay for them. The Network has not developed the capability to bill a person for services. The mindset must be abandoned that a person cannot be billed for services. The Network cannot continue to supplement everyone. The Network must allow those who want to pay to be able to pay for the services they receive. (p. 307)

Mr. **Sushil Sharma**, GAO. What can the Act do to enhance the communication flow? The King County program is trying to meet the needs of culturally and ethnically diverse groups. Within King County, there are other I&A services that do not provide the same multilingual service that the King County program provides. This is the problem with most metropolitan areas which are by their very nature categorized by very diverse ethnic groups.

In Highlandtown, MD, there is a large population of elderly people who do not speak English. They are excluded from the system. Why is the King County program working so effectively, and yet has not been implemented elsewhere? Who should be providing such information? What role should the OAA and the States play in asserting that a targeted population, not currently utilizing available services, could be brought within the network if multilingual services were provided? (p. 308)

Ms. **Abrams**. In Highlandtown, which includes Little Italy and various other ethnic groups, SeniorReach is trying to extend outreach to churches and community groups. Additional services are needed for locals who need interpreters. Foreign-speaking clients have not posed a problem as yet, because there are usually interpreters available. (p. 308)

Ms. **Neeru Dhawan-Gray** [Director of the Baltimore City Area on Aging]. Focal points other than nutrition sites and senior centers can aid outreach to seniors. In Baltimore, highrises, multipurpose centers, churches, and social groups provide additional points of outreach. The groups within the Hispanic and Native American populations must be approached to discover what problems they face with their elderly. (p. 309)

The network must get away from the idea that everything must be paid for. More effort must be devoted to finding what services are available and then to making the linkages happen. The OAA sets the framework in place, but it cannot be the sole source of funding for seniors in this country. One way to alleviate this problem is to elevate the Commissioner on Aging to the status of an Assistant Secretary affording the opportunity to oversee Social Security, Medicare, etc., and to make more integrated policy decisions than are presently possible. (p. 309)

Ms. GAIL MARTIN [National Association of Meal Programs (NAMP)]. First, many of the program's members in Texas that are privately funded are leery of getting into the OAA system because it costs them more money and they are required to do more paperwork. The increased paperwork under greater time constraints requires hiring more personnel, thereby increasing costs. This increase is even more drastic when a privately funded operation like Meals on Wheels in Texas, which receives 48 percent of its funding from the Federal OAA, is required to track their clients but do not have a computer compatible with that of the aging network. The increased costs deter program members from getting involved with State systems.

Second, about 25 percent of the NAMP's members do not receive any Federal money. They survive totally independently. This group does not put any data into the OAA, and the OAA has no reason to request such statistics. But this data would more accurately reflect the total services provided to the elderly from all available sources rather than just the aging network. (pp. 309-310)

LEGISLATIVE RECOMMENDATIONS

The following is a list of all the specific recommendations for amendment to the OAA offered by the panelists and the participants of the second workshop.

Panel I.—Information and referral

1. Specific funds should be set aside for joint ventures between the AAAs and the private sector for program development. (p. 22)*
2. Support and funding should be authorized for demonstration projects that would improve information transfer through a database of medical, sociological, and functional client information. This database should link health providers with available community resources for the elderly. The system must address clinical issues, technical questions, and legal issues. (p. 22)
3. The acute-care hospital should be the point of entry for the frail elderly. The indicators for "frailty" have yet to be defined. (p. 22)
4. All I&R systems funded under the OAA should have a system set up for follow-up on emergency referrals. (p. 25)
5. Additional money should be authorized to assist setting up a tracking system for emergency referrals (see #4). (p. 25)
6. Assessments of clients should be required before long-term care services are provided. (p. 25)
7. The language in the OAA should be revised to allow an AAA to provide I&A services without having to seek a waiver from the State if it wants to provide such services in-house. (p. 26)
8. Create coordinated I&A and case management services at the State level ought to be a regular component of the AAA's ongoing services. (p. 26)

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*Reference is to the pages of this volume where these proposals are described in greater detail.

9. The topic of outreach should be re-examined as a valuable means of cutting costs. (p. 27)

10. All of these models for information networks are intended to address the professional user of the available information. But this information needs to be translated into existing outreach efforts through small community agencies. (p. 32)

11. Hospitals that want to be part of the system, that want information and that are willing to pay for the information should be included in an I&R system to help defray costs. (p. 27)

12. A goal should be to identify at-risk persons before they become sick or develop social problems. (p. 28)

13. Hospitals and emergency rooms should be linked with the Aging Network. Other methods of accessing people should also be developed without creating new bureaucracies. (p. 28)

14. The medical and social networks must be brought into a working relationship which links the resources available within each network. (p. 28)

15. The emphasis should be on a gatekeeper type of program which focuses upon people, other than aging network personnel, who come into contact with the elderly. (p. 29)

16. A computer format that can be shared through the entire State in an economical manner should be developed to allow rural hospitals and tertiary care centers to communicate regarding aftercare programs. (p. 29)

17. All providers, and not simply those persons involved in access and information referral, must be educated in the needs of the elderly. (p. 29)

18. Uniform or universal assessment formats need to be developed for use by hospitals. (p. 29)

19. Information should be effectively integrated into a comprehensive database so that health care information is not completely separate from more general pieces of information. (p. 31)

Panel II.—Information Flow

1. Rather than focus on information flow, attention should be given to the information needs and demands of particular segments of the aging network. Specifically, what kinds of reporting are vital to performing the various mandates of national and State legislation? (p. 33)

2. A continuous manpower database is needed to clearly identify personnel needs on a professional and paraprofessional basis. (p. 33)

3. An empirical study of the information flow, in its vertical or horizontal dimensions, needs to be conducted. (p. 33)

4. With regard to technical assistance, Congress should take steps to enhance the capability of both the AOA and the State agencies to provide technical assistance to the area agencies and to the direct service providers. (p. 33)

5. The AOA especially needs to be given support to get their staff out of the regional offices and into the State and local communities. There must be greater personal interaction with the State and area agencies. (p. 33)

6. The AOA and the State agencies should have more qualified staff. The goal is to establish the AOA and the State agencies as a source of guidance and expertise for the entire aging field. (p. 33)

7. Outreach must be improved. (p. 33)

8. Each State should develop specific consumer guides for their own residents. (p. 34)

9. The Census Bureau, the National Institute on Aging, the National Center for Health Statistics, and the AOA need to collaborate to develop social indicators of unmet need and uniform definitions of key supportive services. (p. 34)

10. Uniform data collection is equally important. Uniform assessment of need must begin by going out into the community and accurately identifying those in need. (p. 34)

11. The types of information presently required by the Network must be re-evaluated to decide if they are necessary, if they are actually being used or if they are simply a waste of time and energy. (p. 34)

12. While it is not necessary that the OAA require each State to have a formal organization of area agencies, it is essential that communication between the State and area agencies occurs regularly. (p. 35)

13. The Act should require improved and current State-specific data on the number of older individuals living at or below the federally defined poverty level income guidelines. (p. 35)

14. State agency staffs should be trained in the appropriate uses of social indicators of unmet need and the application of uniform, standard definitions of supportive services. (p. 35)

15. Congress should require the AOA to strengthen its role in technical assistance. The AOA staff should be able to provide ongoing advice regarding implementation of the OAA. Additional resources should be allocated for site visits to supplement written and telephone advice currently provided. (p. 35)

16. The Act should contain language that accurately reflects the AAA's responsibilities in providing technical assistance beyond the OAA network and in relating to other Federal levels. Specifically, the Act should reflect the AAA's movement into long-term care and the development of private pay systems. (p. 37)

17. The Act needs to develop service standards that assure providers adhere to specific guidelines. Potential clients will then be more certain what services they will receive. (p. 37)

18. SUAs should be much more active in communicating with AAAs so that before a service provider is made available to the public, SUAs will have a more comprehensive understanding of exactly what can be expected to particular services provided through the AAAs. Then the AAA can define the specific details of particular services so that potential clients will better understand what benefits they will be receiving. (p. 37)

19. The AAAs need to develop a working partnership with each other, as opposed to the current adversarial relationship. The aging network should include additional AOA regional offices and should build upon the AAAs already solid relationship with SUAs. (p. 37)

20. There is a need for objective needs assessments tied neither directly to currently available services nor to anticipated service

development. True longitudinal information should also be obtained to measure the actual impact of current services. (p. 38)

21. The aging network should assist service providers by offering information on effective cost-containment practices as well as alternative funding sources. (p. 38)

22. The aging network must take steps to minimize the adversarial component of contracting. With an emphasis on unit cost in competitive bidding, the adversarial relationship between the area agencies and providers is further augmented. (p. 38)

23. The aging network must fight to maintain existing funding while seeking alternative funding for services. Congress must recognize the need for increased appropriations for aging programs as the elderly population and the demand for services increases. (p. 39)

24. Free flow of information between the levels of the aging network requires the different levels to work together as partners. (p. 39)

25. The network should provide information to doctors regarding available services. the doctors occupy key positions because they are generally the system's first contact with an older person.

26. Service costs must be tracked. These data are used to bill the various funding sources for reimbursement. (p. 39)

27. As data are collected, attention must be paid to what kind of data are gathered and how much time is spent collecting them. A critical issue is whether the collected information is actually being used. (p. 39)

28. The Federal Government should make greater use of the structure set up by the OAA with State Offices on Aging and AAAs. (p. 40)

29. The medical model should not be excluded from the network. When the elderly experience sudden deterioration, the so-called "slippery slope," health care and social needs become intertwined. (p. 41)

30. OAA services should be evaluated and validated in terms of outcomes on a model-by-model basis to see what works. (p. 41)

31. Emphasis should now be placed on raising current funding levels. No further services should be added if the funds are not going to be available to pay for it. (p. 41)

32. The OAA should allow the network not simply to do some of the minimal tasks, but to also meet some of the real needs that currently exist. (p. 41)

33. Although the OAA can be interested in long-term care, the emphasis should be upon returning to more general and preventive kinds of services. This issue of long-term care ought to be debated in the same fora as Medicare and Medicaid. (p. 41)

34. Additional public funding must be sought, and strong consideration must be given to private pay systems. The mindest must be abandoned that a person cannot be billed for services. The network must allow those who want to contribute to pay for the servicess they receive. (pp. 41–42)

35. The OAA cannot be the sole source of funding for seniors in this country. One way to alleviate this problem is to elevate the Commissioner on Aging to the status of an Assistant Secretary affording the opportunity to oversee Social Security, Medicare, etc.,

and to make more integrated policy decisions than are presently possible. (p. 42)

SUMMARY OF WORKSHOP III

REAUTHORIZATION OF THE OLDER AMERICANS ACT

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE
ONE HUNDRED FIRST CONGRESS
SECOND SESSION

WASHINGTON, D.C.

JUNE 28, 1990

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INTRODUCTION

In anticipation of next year's reauthorization of the Older Americans Act ("the OAA" and "The Act"), the U.S. Senate Special Committee on Aging, in conjunction with the General Accounting Office (GAO), conducted four workshops in 1990 to examine the efficacy of the Act in its present form and to consider legislative options for improving the social services offered to elderly Americans. Since 1965, the Act has authorized many diverse and important services and programs, including nutrition, employment, advocacy, information and referral, etc. This is the third in the series of informal workshops to examine whether the Act remains appropriate for the needs of the elderly in the 1990's.

This workshop considers barriers to effective advocacy from two perspectives: ombudsman services and legal services. A separate panel of experts addressed each of these topics in turn. An informal discussion between the speakers and the audience followed each panel's presentation. Remarks of Dr. Eli Cohen, a former ombudsman, bridged the two panel discussions. The following summary describes the workshop proceedings, tracing questions raised, issues discussed, and options proposed for amending the OAA.

PANEL I: OMBUDSMAN SERVICES

MODERATOR'S OPENING REMARKS

Ms. Carol O'Shaughnessy, Senior Specialist with CRS. (pp. 315–320*

Title III of the OAA authorizes grants to State and area agencies on aging. These agencies are responsible for carrying out many activities, including administration of supportive services, nutrition programs, advocacy, and coordination of services. Since the OAA was enacted in 1965, Title III has evolved from a funding source for social services to a planning vehicle for comprehensive and coordinated services systems. Title III enumerates at least 20 different services authorized by the OAA. It funds 57 State agencies, 670 area agencies, and over 25,000 local supportive and nutrition services providers.

Title III represents 68 percent of the Act's total 1990 funding of $1.2 billion. The Supportive Services Program under Title III represents 32 percent of total Title III funding and 22 percent of the Act's overall funding. Most of the funding under the Act is devoted to nutrition services. (p. 319–320)

The Long-Term Care Ombudsman Program, charged with investigating and resolving nursing home complaints, evolved from demonstration programs of the early 1970's supported by the Department of Health, Education, and Welfare. The program was expanded in the late 1970's when the Administration on Aging ("AOA") awarded demonstration grants to almost all States to support ombudsman activities. In 1978, the OAA was amended to require each State plan to include a long-term care ombudsman as part of its efforts.

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*Reference is to the applicable pages where the full text of the Workshop III transcript appears.

In 1981, the role of the ombudsman expanded further into board and care facilities. Prior to that time, the program concentrated efforts on skilled nursing facilities and intermediate care facilities. The 1987 amendments to the OAA included provisions that recognized the role of sub-State ombudsmen, prohibited conflicts of interest in the designating of ombudsmen by State agencies, and assured that States provide legal counsel to ombudsmen to protect them from liability. Additional provisions prohibited interference by nursing home operators in ombudsmen functions and prohibited retaliation against ombudsmen. AOA data reveals that there were almost 600 sub-State ombudsman programs across the Nation and approximately $23 million was devoted to ombudsman activities. Over half of his funding came from Title III of the Act, while non-Federal funding accounted for about 41 percent.

Approximately 88 percent of the staff involved in the ombudsman program is volunteers. Consequently, recruiting and retaining volunteer ombudsmen presents a different challenge. The 1987 Amendments required AOA to review role and effectiveness of volunteer ombudsmen and to prepare a report for Congress. Only recently as this report submitted to Congress. The 1987 Amendment also required AOA to complete a study of the effectiveness of ombudsmen in board and care facilities. This study was also recently submitted to Congress. (p. 320)

PANELIST PRESENTATIONS

Mr. James Kautz, State Long-Term Care Ombudsman, Louisiana Office of Elderly Affairs. (pp. 321-323)

Topic: Survey of State and Local Ombudsman Programs.

The survey, to which 46 or 47 State ombudsmen responded, focused on the capacities of the various State programs to provide the services expected of them under the Act. The survey revealed that the residents of the Nation's nursing homes and board and care homes are served disproportionately from State to State by ombudsman programs. Most residents have never encountered an obudsman. In 84 percent of the States, obudsmen visit facilities no more than once a month.

The survey first looked at funding, especially Title III(b) of the OAA. This Title requires States to establish "effective" long-term care ombudsman programs and to provide adequate funding. Neither the Act nor AOA's regulations, however, provide an operational definition of effectiveness, adequate funding, or adequate staffing levels.

If the responsibility of ombudsmen is measured by the number of beds in facilities, then Federal funds are not distributed to the States through a formula that corresponds to the responsibilities of the State ombudsman. The present funding formula is based upon population over the age of 60. Most States received between $100 and $150 of Title III(b) funding per long-term care facility bed. But four States receive less than $90 and seven States receive over $200. The State's spending patterns are also very irregular. The States spend between $2.09 and $68.05 per bed for ombudsman services. Thus, the Act's provision requiring the State to provide adequate funding for an effective ombudsman program has been interpreted differently by the States. (p. 322)

The survey revealed that staffing patterns varied widely among the States. Across the nation, there is an average of one full-time equivalent ("FTE") ombudsman per 3,200 beds. Yet one State provides one FTE ombudsman per 21,500 beds. These FTE ombudsmen are employees, not volunteers. Some States require more responsibilities from ombudsmen than those prescribed by the Act. In these States, ombudsmen often devote one-fifth to two-thirds of their time to nonbudsman activities.

The survey also examined the capacity of ombudsman programs to meet the needs facility residents. Most States do not provide a constant ombudsman presence in the facilities. Only 16 percent of the States maintain an average of more than one ombudsman visit per month to facilities for purposes of getting acquainted with the residents, monitoring resident care, and informing residents of available program services. Board and care homes receive even fewer visits and, in over half of the States, no visits at all.

An important measure of the capacity of ombudsman programs to respond to residents' needs is the proximity of the ombudsman, to the facilities. Only 13 States have an authorized ombudsman, either an employee or volunteer, within a 1-hour commute of all facilities in the State. In comparing cost figures to performance, States in which ombudsmen visit nursing homes at least monthly spend an average of $24.47 per bed. The average cost per bed for an ombudsman within a 1-hour commute is only $17.43.

Based upon this analysis, the current formula for allocation of funding is inadequate, but a better formula has yet to be developed for providing adequate coverage and funding. A more thorough study should be performed before any changes in the current program are made. State ombudsmen should collaborate with AOA and congressional analysts to develop a formula for distribution of Federal funds. (p. 322)

An equitable formula for distributing Federal funds should take into account the base costs required to operate any discrete and independent program like that of the ombudsman. States with only a small number of beds still need a base amount to operate. This base cost would be approximately $300,000. Funding for States with larger bed inventories would be less costly per bed. For States with over 10,000 beds, costs would range from $14 for the largest States to $35 per bed for the smaller, depending upon local economic conditions. These cost estimates assume only monthly visits by an ombudsman and would not support a weekly presence in a nursing home, absent extraordinary voluntary support.

The high turnover rates in some ombudsman programs reflect the difficulties faced by those involved in and committed to ombudsman advocacy. Some ombudsmen realize that they are not meeting the most basic and essential levels of service envisioned by the OAA. They await the improvements that can and must be made in the policies of the Act. The data accumulated by this survey is limited. But the questions asked and the measures of capacity examined should assist the GAO and the Inspector General of the Department of Health and Human Services in their more detailed look at ombudsman programs. (p. 323)

Ms. Anne Kisor, Philadelphia Long-Term Care Ombudsman. (pp. 324-327)

Topic: Perspective of an Ombudsman at the Sub-State Level.

The fulfillment of the OAA mandate to safeguard the health, safety, welfare, and rights of the frail and vulnerable elderly is contingent upon the expansion rather than the limitation of local activities. Barriers to hiring and recruiting ombudsman program staff make achieving the OAA's goals increasingly difficult. The social problems of impoverished areas plague the nursing home industry. The frustrating nature of the responsibilities of ombudsmen, the lack of any permanent and lasting changes, and low salaries combine to increase turnover rates within the ranks of ombudsman program staff.

To offset manpower shortages caused by these problems, novel and creative staffing models should be adopted. The potential for growth of the program rests on the adequate use of volunteers. Volunteers embody the spirit of community service, which is critical as long-term care moves from a private to public concern. Volunteers embody the spirit of community service, which is critical as long-term care moves from a private to a public concern. Volunteers, when properly trained and supported, can assist nursing home residents in processing and handling complaints. (p. 324)

One of the crucial components to achieving a successful ombudsman program is an extensive training and screening program for all volunteers before they engage in on-site visitation. Volunteers range in ability and experience. An extensive training program will provide the common ground upon which the volunteer ombudsmen can then build.

Currently, most local ombudsman programs operate with a mix of volunteers and professionals, but not necessarily with a uniformity of intent. The 1991-93 Pennsylvania State plan on aging proposes a wider use of volunteers as a priority for future development. Hands-on involvement and organizational directives on the State level, coupled with a standardized and consistent process at the sub-State level, are crucial if volunteers are to enter and remain in the complaint handling process.

The relationship between the State office ombudsman and local programs extends also to the formal and informal policies and procedures that govern the daily operations of the local programs. Leadership on the State level should be characterized by several interrelated objectives intended to make the ombudsman's responsibilities more reasonable. This can be achieved by setting statewide goals and uniform performance standards, providing continuous training and support, and serving as a resource center for interpretation of the OAA. (p. 324, 325)

In addition, the State office should be responsible for developing interstate departmental policy directives. This is especially important in developing a relationship with the State licensing and certification agency in terms of understanding the respective roles and providing access to information.

The State office should also be responsible for sharing appropriate information with the local units necessary for the local ombudsman to perform his or her duties. Policies should be translated in unambiguous terms at the local level. This is essential to the fulfillment of the local professional ombudsman's obligation to inform and empower residents with current information on laws, regulations, and policies.

The State office should be obliged to forestall any policies or procedures that might have unanticipated negative effects upon sub-State programs. For example, the State must avoid creating a burdensome reporting system which would have a potentially negative impact upon nursing home residents' ability to resolve complaints in a timely fashion. Also, the State should avoid interferring in professional relationships on the local level. The ombudsman must have relatively unfettered freedom to develop collaborative relationships with other individuals and community agencies. Toward this goal, considerable latitude is given to the local AAAs in most States to interpret policy directives. (pp. 325)

On the other hand, ambiguous policy directives cause frustration for ombudsmen on the local level. The State office, the AAA, and the subcontracting agency will often disagree as to the role each is to play in effecting an ambiguous policy directive. The local ombudsman must grapple with these divergent opinions and interpretations.

The vague language of the OAA allows for a wide variety of interpretations of the term "ombudsman." Is the ombudsman an impartial mediator or a resident advocate? The advocacy role is implied in the 1987 Amendments to the OAA, suggesting a proactive role that extends significantly beyond the bounds of a mediator. What happens when a resident's needs forces the ombudsman beyond his or her prescribed role as expressed through policy directives? Is impartiality a realistic goal for ombudsmen called upon to represent the needs, interests, and desires of residents? Several States have enacted legislation to provide a framework for advocacy to address these issues. Current statutory language, however, allows local ombudsmen to investigate and identify problems and to make recommendations, but not to initiate change. (pp. 325–326)

The mediator-advocate dialectic offers no easy solution. Discretionary interpretation of the proper role of the ombudsman may undermine the intent of the Act by erecting barriers to effective advocacy. On the other hand, it is impossible to add specificity to the Act without narrowing the available options for flexibility in ombudsman programs. To realize the Act's mandates requires expansion rather than limitation of sub-State activities. It is still unclear whether the initiation of enabling legislation specifically dealing with advocacy or enhanced local program development will resolve this issue.

Conflicts in role interpretation also extend to the ethical dilemmas confronted by the local ombudsman trying to effectively represent cognitively impaired residents. Direct resident involvement in the handling of complaints is not always the norm. Approximately 50 percent of nursing home residents have some degree of cognitive impairment. It is often difficult to determine a resident's ability to make decisions consistent with his or her values. Although the Act explicitly provides for the resident's rights to control the investigation of complaints, it is sometimes impractical to permit the resident to do so. (p. 326)

General principles, such as the proposed ombudsman code of ethics, exists to guide the ombudsman in this area, but the ombudsman must always be sensitive to the potential conflict between personal and professional values. A large number of cases involve an impaired resident who has not been subjected to a competency hearing and has not issued any advance directive to guide the investigation. As a rule, the ombudsman may use substituted judgment and speak for the resident. But the ombudsman may not have an intimate knowledge of the resident's value system necessary to perform this function.

The persistence of this issue demands a long-term solution, not a case-by-case approach. The need for a long-term solution increases as the number of cognitively impaired residents grows. Intensive training is needed on the local level as well as a greater focus upon statewide policies and standards. A specific remedy, such as carefully drafted enabling legislation, is essential if the local ombudsman is to be an effective representative and advocate for all nursing home residents, regardless of their degree of impairment. (pp. 326–327)

Senator David Pryor. (pp. 327–328; prepared statement p. 313)

Today's discussion considers barriers to effective advocacy on behalf of vulnerable senior citizens. This workshop will focus on two advocacy programs which will be central to the debate surrounding next year's reauthorization of the OAA: defining the appropriate role of the ombudsman and strengthening legal assistance. In the 1978 Amendments to the OAA, Congress required each State to establish a long-term care ombudsman program. Since that time, ombudsman programs have expanded dramatically across the country, providing vital advocacy services to vulnerable residents of nursing homes and board and care facilities. (p. 313)

Despite these substantial achievements, the unfortunate fact is that we cannot assure advocacy services to all residents of long-term care facilities who are at risk. Today's workshop is designed to explore what steps can be taken in the OAA reauthorization to remove obstacles to effective ombudsman advocacy.

In contrast to the ombudsman program, elderly legal services have been provided since the early years of the OAA. In 1975, Congress recognized the critical importance of legal assistance and declared it a "priority service." However, a longer history has not necessarily assured legal services programs greater success. Organizations and private attorneys providing OAA services face substantial barriers to providing effective legal advocacy. This workshop addressing legal services should examine these problems and propose suggestions for OAA reauthorization. (p. 313)

The focus on ombudsman and legal assistance programs is not meant to suggest that these are the only OAA advocacy programs. On the contrary, all members of the aging network and all OAA services serve as advocates for older persons. Looking toward next year's OAA reauthorization, strengthening advocacy efforts will require greater attention and hopefully a stronger commitment from Congress as the elderly population in nursing facilities increases. (p. 328)

Ms. Susan McDonough, State Long-Term Ombudsman, Massachusetts Department of Elder Affairs. (pp. 329–333; prepared statement pp. 334–337)

Topic: The Massachusetts Ombudsman Program.

The Massachusetts ombudsman program was one of the first demonstration programs in the country. The development of local programs in Massachusetts began in 1977. Today, there are 27 programs with 317 ombudsmen. Each of the 745 nursing homes and board and care facilities receives a weekly or bi-weekly ombudsman visit. The annual budget for the ombudsman programs is $1.8 million, $1.6 million of which is Title III funding. Of the 6,600 complaints received and resolved last year, 88 percent were resolved on the local level. Prior to the development of local ombudsman programs, the State office received less than 200 complaints annually.

Consistent and regular visitation to long-term care facilities promotes the use of ombudsman services. The frail elderly have difficulty calling or writing for assistance. Although weekly visits are the norm, the ombudsman cannot possibly visit with every resident in the facility. Approximately 30 residents are seen during each 3-hour visit, so every resident in the facility receives a visit from an ombudsman within a month. (pp. 329; 335)

Residents, if they are to register a complaint, must trust the ombudsman; to trust the ombudsman, the resident must know the ombudsman and know that the ombudsman will protect them from retaliation for filing the complaint. A regular presence in a nursing home provides the ombudsman an opportunity to better identify patterns of problems for which general complaints can be registered. The key to the success of the programs is that complaints are registered without using a resident's name. Consequently, problems are reported without fear of retaliation. They can then be identified and addressed before they become crises.

Massachusetts is the only State to provide weekly visitation to board and care facilities. Advocacy in board and care facilities is difficult. Massachusetts board and care facilities are not strictly regulated. They have fewer staffing patterns and often do not have detailed plans for social work service and activities.

Board and care facilities are required to be inspected regularly every 2 years. But there are facilities in Massachusetts that have not seen a licensing or certification person in 5 years. The staffs are often untrained; the residents in many facilities are cognitively impaired and lack the capacity to advocate on their own behalf. In addition, some unlicensed facilities do not receive ombudsman visits because they physically do not look like board and care facilities and are hard to identity. The current focus of the local ombudsman programs on board and care facilities, or rest homes as they are called in Massachusetts, is a result of the serious cases of abuse and neglect discovered in these homes. This marks a significant change from the program's original focus on nursing homes. (pp. 330; 335)

The State office encountered great difficulty in attracting AAAs to participate in the ombudsman program. The Act does not require that agencies operate of fund ombudsman programs. The Act simply requires AAAs to "support" such programs. Many of the services that AAAs provide are directed to forestalling or eliminating institutionalization. Toward this end, the AAAs believe their money is better spent on community-based services. In addition, the AAAs compete for Title III funding. This conflict in priorities on the local level increased resistance among the AAAs toward ombudsman programs.

By 1983, at least half of the AAAs provided ombudsman programs. In 1983, Massachusetts included a mandate in the area plan requiring a local ombudsman program. Currently, the State requires all agencies to operate or subcontract a program, sets staffing pattens and supervision requirements, and formally designates programs with clearly articulated standards and policies. In 1987, wages were set for the program directors at the local level. In 1988, funding of the local programs came within the authority of the State unit on aging.

Similar models exist in California, Texas, Mississippi, Louisiana, Oklahoma, Ohio, and the District of Columbia. The common characteristics of these model State programs are as follows: A mandate to the AAAs to operate local ombudsman programs; regularly set staffing patterns for supervision on the local level; development and review of local budgets; staffing on the State level, in addition to the State ombudsman, to coordinate local program activities; clearly articulated policies; regular evaluation processes including the power to change a contractor or withdraw funds if the local program is not in compliance; strong State enabling legislation; large corp of volunteers; and supportive environments. (pp. 331; 335)

In the area of advocacy, Massachusetts ombudsmen are considered major players in the State's long-term care policy development. No regulation involving long-term care services is developed without the input of the State's ombudsman office. Further, the State office often initiative regulatory and legislative changes.

The above model programs assert that they fulfill the mandate for advocacy because they have the time and the access to residents that effective advocacy requires. Regular visitation provides a sound base for effective advocacy. Unlike other State agencies, the State ombudsman office has very current information because the ombudsmen have been in the facilities and can accurately assess the environments. Consequently, the State ombudsman office is directly aware of an individual legislator's constituency problems and the problems that exist in individual nursing homes.

Further, all ombudsmen scrupulously comply with the mandate for confidentiality regarding complaints. The State office has successfully protected its files from challenges seeking access, but more control in this area is needed. Massachusetts, like most States, has a State abuse reporting law that is in direct conflict with the OAA. Most State ombudsmen report abuses if they believe a resident's life or safety is in danger and will do so without permission to use the complainant's name. Clarification is needed that would permit disclosure of a complainant's identity where people's lives are in danger despite the absolute mandate for confidentiality. (pp. 333; 336)

Ombudsman programs must expand. Fewer than 10 States provide at least monthly visitation to nursing homes in their respective areas. Many of the existing programs are poorly funded and they compete with other important programs for available resources. Even those programs that are properly funded are in jeopardy because they rely heavily upon Title III funding. In Massachusetts, 95 percent of the funding comes from Title III, necessitating the elimination of services as Title III funding fails to expand.

Prior to placing any further mandates on ombudsmen, the GAO and the Inspector General should examine the existing program models in the country. Many State ombudsman offices try to excel in service delivery and advocacy for the residents of nursing homes and board and care facilities. But they are obliged to fulfill additional mandates imposed by the States, such as the investigation of community-based abuse services or the provision of advocacy for people receiving in-home services.

Expansion of the long-term care ombudsman program should not come at the expense of the facility residents. Ombudsmen are the only contacts many residents have. They do not routinely access the other services available other than legal services. Ombudsmen are the only people that personally visit residents to help them with their problems. (pp. 333; 339)

The Massachusetts experience suggests the following recommendations for the reauthorization of the OAA. Any recommendations for change in the current system cannot reduce the current level of service upon which so many elderly rely. The Act should define ombudsman services as a priority for AAAs. The Act should specify a separate funding process and establish a level for funds that do not place long-term care ombudsman services in competition with other community-based services. Residents of nursing homes and board and care facilities should have access to all elder services, such as transportation and legal services.

Further, the Act should clearly state that ombudsmen may disclose the resident's name without consent if the resident's life or safety is in serious danger as a result of abuse or neglect. The AOA should be required to conduct an in-depth study of the effectiveness of the present ombudsman programs and to require corrective action in states determined to be out of compliance with the OAA.

The Act should also describe the necessary components of an ombudsman annual report to ensure a proper focus on the important issues. The OAA should define regular visitation and emphasize the importance of services to board and care residents. Finally, funding of the National Resource Center should continue. (pp. 333; 339)

Mr. Ronald Hornbostel, Ohio State Long-Term Care Ombudsman. (pp. 338; prepared statement p. 343–352)

Topic: The Ohio Ombudsman Network.

The Ohio ombudsman network consists of 12 regional programs, 7 of which are operated directly by the AAAs while the 5 larger programs contract with the AAA to provide ombudsman services. The network is relatively well-funded with 40 percent of the funding coming from Title III, 40 percent from State appropriated dollars and 20 percent from private organizations, such as church groups and private individuals. (pp. 338; 343–344)

Last year, the network processed 9,500 complaints filed on behalf of residents of nursing homes and board and care facilities throughout the State. The 1987 OAA Amendments, which strengthened ombudsman programs, provided the impetus in Ohio to pass a strong ombudsman enabling law. The Ohio legislation has only been in effect for 2 weeks, but contains certain provisions of particular interest. First, the regional programs require each nursing facility to pay from its profit $3 per bed to support the ombudsman. Also, the law expands the ombudsman's authority to respond to complaints filed on behalf of recipients of community-based long-term care services. This mandate should not be expanded without the infusion of new funding necessary to support this service.

In 1981, the OAA expanded the mandate of the ombudsman program to serve residents of board and care facilities. Ten years later, the States are still struggling to implement this mandate and must now implement a new mandate to expand services to people who receive community-based long-term care. The Ohio General Assembly made a specific appropriation, $540,000 a year, to support this new mandate to expand services to encourage the ombudsman programs to accept the additional responsibility. (pp. 339; 344)

In addition to implementing the provisions of the 1987 OAA Amendments, Ohio has struggled through its enabling legislation to emphasize the right of an ombudsman to pursue administrative and legal remedies on behalf of nursing home residents. Toward that end, the enabling legislation contains two important provisions.

First, ombudsmen have standing to bring suits on behalf of residents who feel that their rights are violated by Ohio facilities. Second, the State office, and only the State office, has subpoena powers. This is a potentially potent mechanism for gathering evidence.

In the area of legal representation for the ombudsman program, three discreet areas require exploration. First, ombudsmen who are sued in the performance of their duty need legal representation. Second, ombudsmen need access to legal advice and counsel on a daily or even hourly basis. Third, legal counsel is needed to represent the concerns of residents in litigation in which the ombudsman either supports or serves as plaintiff. (pp. 339; 347)

The Ohio ombudsman network has explored numerous possibilities to fulfill the mandate that the State agency provide legal advice, support and counsel to the regional programs. For example, the 1987 OAA Amendments, in defining the staffing patterns of the State office and regional programs, envision a model in which the States' Attorneys General are compelled to represent the State and local ombudsman programs. Many States, including Ohio, would like to implement this model. The barrier that the States face in this regard is that the Attorneys General offices are frequently at a severe competitive disadvantage compared to counsel from Washington, D.C. that represent the nursing homes.

Since the Ohio ombudsman have standing to sue on behalf of facility residents, the Ohio Attorney General must represent those residents whose rights are implicated in a suit. The State Department of Aging has a contract with private legal counsel who is very familiar with the ombudsman program and is able to provide representation and advice where the Attorney General's office will not become involved. This is especially iomportant when a subpoena is issued to the ombudsman program but the ombudsman is not a party to the litigation and therefore does not qualify for legal representation by the Attorney General's office. (pp. 340; 350)

In addition, stronger ties between the ombudsman program and the legal services network funded under Title III must be established. The barrier to bringing these two vital programs closer together in a working relationship is that neither understands the other's priorities in terms of the provision of ombudsman services. This is one of the most critical issues for the 1990's.

The notion that the ombudsman program is going to serve every person and every need is simply not realistic. On the other hand, legal services, especially the LSC-funded programs, have clearly developed priority structures that determine which cases to pursue. Uniting the legal services network with the ombudsman program requires each to understand the other's priorities and identify shared priorities. (pp. 340; 350)

The ombudsman program can directly influence the priorities that will determine whether the Title III legal services program will represent nursing home residents. First, the ombudsman program should actively be involved in establishing the priorities with the legal services provider. This approach has proven successful in Ohio. Second, a contract or memorandum should be drafted to mandate a working relationship between the ombudsman program and the legal services provider in each region. This has yet to be accomplished in Ohio.

Another approach that has proven useful in Ohio is cross-training of the ombudsman and legal service providers on the average of once a year. The programs intersect on a more regular basis through the ombudsman programs' inclusion of legal services attorneys, and private bar as well, on their boards of directors and boards of trustees. In addition, ombudsmen serve on advisory councils and task forces for the various legal services provider agencies in Ohio. (pp. 341; 350)

Of the following recommendations for the reauthorization of the OAA, two are modest in scope while two are probably too ambitious. First, the confidentiality provisions of the OAA need to be strengthened and clarified. Second, the back-up centers for the ombudsman programs, especially the national back-up centers, should have increased funding to perform their vital functions which assist training, provide materials, and educate people about the ombudsman program. Additional funding should also be provided to the national legal services back-up centers which provide invaluable support for advocacy for nursing home residents. (pp. 341, 342; 351)

Third, matching grants for home care ombudsmen should be provided through the OAA to encourage State general assemblies to separately fund home care ombudsman activities. This would avoid burdening ombudsman programs with additional mandates without increased revenue. Finally, in terms of overall funding of the ombudsman programs, a separate title should be added to the OAA to fund the advocacy services provided through both ombudsman programs and legal services.

No adequate funding formula or needs assessment has been developed to address the concerns of either of these two programs. The problem is not the programs but the methodology currently used to fund Title III services which promotes competition for funding between ombudsman programs and the Title III legal service providers. (pp. 342; 351)

PARTICIPATION FROM THE AUDIENCE

Ms. O'SHAUGHNESSY. Before the open discussion begins, it may be helpful to identify a number of the major themes articulated by the panelists in their presentations. Many of the panelists raised the issue of the need for regular nursing home visits to develop working relationships with the administrators and residents. This kind of visitation provides the ombudsman with a framework for advocacy.

Confidentiality requirements and potential conflicts of interest were also discussed. Some States have mandatory reporting requirements for instances of eldery abuse, but the Act requires confidentiality. Mr. Hornbostel and Ms. McDonough raised questions about expanding the role of the ombudsman in home care. Related to these points was the call for a strong State mandate for the ombudsman program.

Other issues included the need for data on ombudsman programs. But burdensome reporting requirements from the State are not necessary nor beneficial. The role of the ombudsman is to prompt other systems to perform their respective tasks. Finally, the ombudsman must have legal protection. (p. 353)

Mr. Schulder, National Council on Aging: No one discussed in any detail the role of the volunteer ombudsman in the different ombudsman programs. What are the benefits and costs of utilizing volunteers? How critical are volunteers to the programs currently operating and what role should they play in terms of the Act's reauthorization? (p. 353)

Mr. KAUTZ. First, our study did not research the numbers of volunteers involved in ombudsman programs because there was no time to collect that data. To do so would have proven too great a burden on those reporting. (p. 353)

In Louisiana, numerous attempts have been made, using a variety of methods, to involve volunteers in ombudsman programs. The most successful efforts were in the urban areas. In rural areas, the involvement of volunteers has been more difficult in large part because the ombudsman must often become involved in conflicts with local persons. The major employer in a small town, namely the nursing home, may cast the local ombudsman in a negative light because of these conflicts. Many people in small town environments are unwilling to take this risk. They will visit the nursing homes, but will not assume the ombudsman's responsibility. Consequently, other roles for volunteers, besides that of direct ombudsman, have been developed. Although 88 percent of the personnel within the programs are volunteers, this figure requires some explanation.

The Louisiana programs have two roles for volunteers. One is the long-term care visitor who is not an authorized ombudsman and does not have the training nor the authority simply as the eyes and ears for the ombudsman. The other role for a volunteer is as a certified ombudsman, as specified under the Act. The 88 percent figure is a combination of both types of volunteers. (pp. 349–350)

The role of the volunteer is very important and has been successful in many areas. But volunteers require a substantial amount of good, professional support to retain them and avoid a rapid turnover. For example, they must have training, which must be provided in the evening when the volunteers are not working their regular jobs. Although volunteers are not paid, the volunteer program requires funding. Without the necessary support behind them, volunteers should not be brought into such a demanding, difficult environment. (p. 354)

Mr. John McMannis, a volunteer ombudsman: No one has spoken of community involvement. The panelists' emphasis on Title III seems to omit the importance of community involvement. If community involvement were included in the program, community support for the legislative backing being sought would likely follow. In fact, it was community pressure that impressed upon Congress the need for an Administration on Aging to care for the elderly. (pp. 354–355)

Volunteers are critical, but once the programs become established, the volunteers are neglected. The cost of not having volunteers exceeds the cost of maintaining their involvement. A national organization of volunteer ombudsmen should be created to prompt discussion of volunteering and investing money in those activities for which ombudsmen are necessary. These new dollars are available, especially if community support were cultivated through pressure from the existing aging network. If the community called for attention to the elderly, Congress would have to listen. (pp. 355–356)

Ms. McDonough. In Massachusetts, the staff of 300 includes 226 volunteers. Texas utilities 516 volunteers and California has 700 volunteers. The Massachusetts ombudsmen, whether volunteer or paid, do exactly the same work, are trained in exactly the same manner, and provide exactly the same level of service. The only difference between paid and volunteer ombudsmen is that those who are paid work 40 hours per week while volunteers are only expected to work a minimum of 400 hours per year. (p. 356)

In short, the role of volunteers is taken very seriously in Massachusetts. They receive 5 days of training and regular certification. Monthly in-service education is also required. Every local ombudsmen is recertified on a biannual basis. The ombudsmen receive updated policies and procedures manuals as well. More than half of the Massachusetts staff of volunteers has been working for more than 5 years. To continue these efforts, more funds are needed.

But supervision for volunteer ombudsmen on the local level cannot be provided by the State ombudsman. A staff person in a local agency is necessary to provide supervision for ombudsmen, who visit nursing homes and may encounter a problem that they cannot resolve themselves or need some back-up. Absent this local support, the volunteers question if their actions are appropriate and they do not stay in the program very long.

Also, travel money is needed given the age of many of the volunteer ombudsmen. In Massachusetts, the ombudsmen are not able to pay for their own travel. Most of them are over 65 years old. Even though they are not paid for their work, they must be paid for their travel expenses, including parking in urban areas and bus passes. Further, volunteers need affirmation that they are performing well, which may require an annual lunch or some other activity that will cost additional money. (pp. 356–357)

Finally, half of the $24 million that funds the national aging network is Title III money. Almost $2 million of that $12 million is in Massachusetts. Weekly visits to facilities, extensive information gathering, and productive advocacy would never be possible without the program's ability to support the volunteer ombudsmen. Massachusetts illustrates the need for more money. Although it is one of the best funded programs in the country, the Massachusetts, ombudsman program is still struggling to provide services and support volunteers. (p. 357)

Ms. Enid Cassner, American Association of Retired Persons: Would Mr. Kautz explain how the States estimated the number of board and care beds. Are only the licensed facilities included in the figures cited and, if so, are services only provided to licensed facilities? If services are provided more broadly, then could the study have understated the degree of service provided to board and care facilities? (p. 357)

Mr. KAUTZ. The States reported what they considered to be their clientele in the board and care areas. No sophisticated definition was developed for the study. In Louisiana, all licensed facilities were included as well as those "subject to be licensed." Obviously, those facilities that successfully avoid the licensing requirement by moving from place to place are difficult to identify for a study such as this.

As more attention is focused on board and care homes, the numbers of residents of those homes and the numbers of those facilities will expand very rapidly, not because more places will open but because more places currently in existence will be located. This study considerably understates the responsibility of service providers in terms of board and care beds. (p. 357)

Ms. Virginia Frazier, Colorado State Ombudsman and President of the National Association of State Long Term Care Ombudsmen:

Given the difference in per bed funding between Mr. Kautz' program and Ms. McDonough's program, what would Mr. Kautz change about his program if he had similar resources? (p. 358)

Mr. KAUTZ. The Massachusetts program, because it is so well funded, can invest time and money in systemic reform efforts. Sophisticated approaches, such as speaking with key legislators or filing class actions, can be attempted to effect positive changes for hundreds of residents with one sweeping act. In contrast, these activities are not possible in States such as Louisiana, where the available funding is spread throughout 31 AAAs. The focus in such a program must be on individual cases rather than on sophisticated systems impact cases.

The success of ombudsman programs cannot be assessed on the basis of how often ombudsmen visit these nursing homes. There is a limit to how much systemic reform can be achieved unless people are actually in the field meeting the nurses, residents, and other nursing home personnel. Nevertheless, some programs have chosen to allocate funds to provide for this systems advocacy. A program is not an unsuccessful program simply because it does not provide weekly visits to every nursing home. This is surely a desirable goal, but it costs money and volunteers to reach that point. The Massachusetts program accomplishes what other progams are unable to do at existing staffing and sophistication levels. (p. 358)

Mr. David Harvey, National Association of Protection and Advocacy Systems:

No one has discussed the cooperative efforts at the State level between Long Term Care Organizations (LTCO) and State Protection and Advocacy agencies (P&A). P&A agencies are authorized by separate legislation and provide legal assistance to people with disabilities. The 1987 reauthorization of the OAA mentioned facilitating efforts between LTCOs and P&As. (pp. 358-359)

Mr. HORNBOSTEL. The Ohio protection and advocacy agency, the Ohio Legal Rights Service, contains a separate ombudsman program that serves mentally ill and mentally retarded persons in a way that the P&A organizations traditionally do not serve them. Specifically, the Ohio ombudsman program investigates and handles individual complaints that may not lead to litigation. The Ohio long-term care ombudsman program has worked closely with the Ohio Legal Rights Service, but at some points they seem to be in conflict.

The thrust of protection and advocacy agencies seems to assure that the people served receive community-based services as opposed to institutionally based services. Some ombudsmen have been told that their function is less important because they serve people already receiving some protection within institutions. Of course, the Ohio P&A agency knows this is not true. (p. 359)

Ms. Jean O'Lawney, The American Association of Homes for the Aging:

First, how do the ombudsmman programs relate with the State survey and certification system, which inspects the quality of care? Second, how do the ombudsmen relate to the facilities, the administrators, the clinicians, et al., and what steps are taken when exceptional care is found in a facility? (p. 359)

Ms. MCDONOUGH. The Massachusetts State ombudsman's office has a strong relationship with the licensing and certification agency regarding who will perform what activity and when. Generally, the ombudsmen will try to resolve the complaints in the facility. The ombudsman program has an excellent reputation within the Massachusetts provider community for working together to resolve complaints. Consequently, ombudsmen rarely have to refer complaints to a regulatory agency for resolution. These complaints are resolved by the providers. (p. 359-360)

Ombudsmen also investigate all reports of residents' rights violations for the Department of Public Health in Massachusetts. State law requires that all instances of abuse in nursing homes be reported to the State licensing agency. Only those cases that cannot be resolved by the ombudsmen will be referred for resolution to the licensing agent. (p. 360)

The ombudsman program provides monitoring of the survey documents and the plans of correction. All ombudsmen receive surveys with the plans of correction for facilities attached. If a facility, cited for serious violations, is not adhering to the plans of correction, then our office is contacted. The State certification agency is then notified to perform a review of the facility.

The ombudsman progams also have a strong relationship with the State providers in Massachusetts. The State providers understand that if the ombudsmen cannot resolve a complaint, it will be referred to a regulatory agency. There is a constant effort to identify those providers who are doing a good job.

Currently, the focus of this effort is upon board and care facilities. With the exception of the Executive Office of Elder Affairs, Massachusetts has pretended for some time that these facilities do not exist. The effort now is to compel State government officials to look at those facilities that are good providers and try to replicate them. The providers believe that the recommendation will be for improvements in rates as they improve the quality of care for residents. On certain issues, then, providers and ombudsmen stand as allies while on other issues, such as Medicaid discrimination, there is disagreement. This is a good blend for a working relationship. (p. 360)

Ms. Elma Holder, National Citizens Coalition for Nursing Home Reform:

It is very important for the Senate Committee on Aging to look at this effort to strengthen ombudsmen programs, particularly in view of the new nursing home reform law which will be implemented in October. Ombudsmen and their services, whether paid or volunteer, will be essential to the successful implementation of this reform law. This is the appropriate time to strengthen the ombudsman program, assuring that the advocacy role continues and that the necessary funding is provided at every level. (pp. 360–361)

Ms. Kisor. Many of the people here today represent effective and efficient State programs for residents. But most States do not enjoy such success as Mr. Kautz' research reveals. Pennsylvania has experienced considerable difficulty in achieving uniform intent on the State level, which filters down to the day-to-day operations of the program?

It is particularly important to develop a working relationship with the State certification agency. As the ombudsman now takes a greater role in the survey process, the need for this working relationship amplifies. Without further direction on the State level, ombudsmen are asked to work with the local departments of health, which in the end will only undermine the intent of the Act for the residents. (p. 361)

LUNCHEON PRESENTATION

Dr. Eli Cohen, Vice President of the Philadelphia Community Services Institute. (pp. 362–367; prepared statement pp. 368–370)

Topic: Overview of Long-term Care Ombudsman and Legal Service Programs.

Changing the boundaries of the legislative mandates or authorizations would not likely affect the problems and issues that deserve greatest attention. Other programs with minimal resources were changed through successful intervention, illustrating that systemic reform may be unnecessary. (pp. 363; 369)

The appropriate starting point is to look at the interface between moral obligation and legal obligation. The vindication of the civil rights of persons traditionally relegated to lower class status has always been preceded by advocacy of individuals who have asserted their rights acquired under natural law. This is true of African Americans, Native Americans, women, the disabled, the mentally retarded and, to some extent, the elderly.

This process begins with the recognition of a moral obligation toward a specific group. Then, legislation is promulgated which incorporates the moral obligation into state law. This law is then interpreted and defined through the court system. An example of this process is the history of African Americans.

There are limits in our system. The legal obligation will not likely evolve to prohibit private discrimination. The bounaries of prohibited public discrimination will continue to expand, but it will at some point reach an outer limit. The only restriction beyond that will be moral obligation. Public responsibilities, such as education and political leadership, will help to change and to define this moral obligation.

Moral obligation, when generally accepted, produces wider, deeper, and more effective behavioral change than does simple law enforcement. In this connection, there is a limit to how far health regulation or the regulatory processes involving nursing homes will attain the standard that we as individual's desire to meet our particular personal needs. This is not to say that regulation is not essential, but only that it alone is not sufficient. (pp. 364; 368)

The propensity to turn to the legislature or Congress for a solution must be overcome. The civil rights of people in nursing homes are being overridden on a daily basis. One approach to this problem is to increase efforts at enhancing the public understanding of the moral obligation to the elderly. The intent of this effort should be to increase the effectiveness and better define the parameters of the legal obligations.

The current focus upon legal and legislative formulations has limited the potential for change by adopting such legal standards as the least restrictive alternative for the elderly. This is a very low goal when the optimal goal is to avoid entering nursing homes at all. But even this optimal goal omits other important notions such as an individual's right to flourish, which has been virtually ignored by the aging movement. Unlike the women's movement or the mental retardation movement, the aging movement has failed to achieve an intellectual unity between the moral and legal obligations.

For example, patients afflicted with Alzheimer's disease can flourish, albeit differently. They live in small periods of time requiring a different point of view among caregivers to ask if the patients can flourish at this very moment rather than assessing them in terms of healthy individuals. (pp. 365; 369)

A number of factors have been cited as barriers to more effective long-term care ombudsman and legal services programs, including access, jurisdiction, standing to sue, conflicts of interest, independence of the programs from their respective funding sources at the State or sub-State levels, insufficiency of resources, the need for training, and inadequate public protests and demands for reform. But these barriers, while real enough, are fortified by the inattention to system reform. Those involved in legal services programs should begin to provide comprehensive services. Legal advocates should perform the public relations, the legislative analysis, and draft the press releases. (pp. 365; 369-370)

System reform would necessarily address the categorical approach. Applying this approach, the mental health system excludes elderly suffering from brain damage despite the benefits they could enjoy from the system, the health care system excludes the chronically disabled, and the social service system excludes the chronically mentally ill. Into that category do the homeless elderly fit? The inattention to system reform suggests limited vision on the part of those charged with leadership.

What is the vision of the ombudsman and legal services programs? If they were 100 percent successful in realizing this vision, would the programs change? Is the vision of the AAAs and the State units simply to garner resources for categorical approaches or is it to create an environment in which all elderly can flourish and grow? (pp. 365-366; 369)

In Pennsylvania, great amounts of money are invested in aging. But Pennsylvania needs to create an environment in which the elderly know that they will be protected, that they will receive good medical care and full social services, that they will receive transportation to those places important for a full life, and that they will be able to work if they desire.

The time has come to examine other models and the advocacy strategies that were pursued. These alternative models project a different point of view. A careful look at the women's movement or the independent living movement may suggest new strategies and improvements on existing strategies.

Some elements of system reform are in place while many are not. Current and future needs must be assessed. A vision of what goes into system reform must be developed at the start. Then, an understanding of the systems, especially their limitations and their failures, and the distribution of power within these systems must follow. (pp. 366; 369)

In addition, those charged with carrying out this process must have the courage to overcome the barriers to system reform, including the conflicts with the funding agencies upon which the programs presently rely. This will require independence of the programs from their funding sources. Legal services in Pennsylvania receives money from an agency and still may proceed to sue that agency.

This process requires the courage to utilize all the tools available and essential to system reform, which includes the empowerment of consumers, the constructive use of tough publicity, and the development of innovative forms.

The focus of system reform should not be exclusively upon the procedure and the process, but rather upon the broader goals: the conduct of the underlying legal and substantive research essential to advocacy system reform, the use of State law, and the cultivation of a sense of moral obligation. Also, Title I, the purpose section of the OAA, should be taken more seriously. Do the strategies presently employed achieve the goals so well articulated in Title I? Or are the programs obsessed with technique over purpose? (pp. 367; 370)

In sum, the reauthorization of the OAA should be viewed as an opportunity to explore some different perspectives. The power of moral obligation, and the role of government in enhancing the sense of moral obligation, should be considered. System reform should be considered as important as the current case-by-case approach to complaint resolution. Finally, any provision of the OAA, when considered during the reauthorization process, should be considered in the context of Title I. (pp. 367; 370)

PANEL II: LEGAL SERVICES

MODERATOR'S OPENING REMARKS

Ms. O'SHAUGHNESSY. The second session of this workshop will focus upon legal services, one of the three priority services under the OAA. The Act requires each AAA to spend an adequate proportion of funds on legal services. The Act does not define what constitutes an adequate proportion, but instead allows State agencies to determine what should be the minimum proportion spent upon legal services. This has been a persistent problem for States. States may also grant waivers if the AAA demonstrates that adequate legal services are being provided in the planning and service area.

More data is needed to define what is an adequate proportion of funds. States have simply decided upon the minimum percentage to be spent on legal services. The Senate Special Committee on Aging is currently conducting a survey on legal services and has sent a questionnaire to all State agency directors. The early response has been very good and the Committee will contact these State agencies again to determine what additional information is needed. (p. 371)

The Committee intends to publish the findings of the survey upon its completion. Three preliminary findings are relevant to this workshop. First, relatively few law schools and nonattorney advocacy programs receive contracts for Title III funding. Second, States employ a wide variety of measures for determining the amount and type of legal services that contractors provide. Third, for the States that provided information regarding cases handled by legal service providers, the most common cases involve consumer protection, durable power of attorney in living wills, estate and probate matters, and housing. (pp. 371)

PANELIST PRESENTATIONS

Ms. Anne Fisher, Staff Attorney with the Legal Assistance Foundation of Chicago. (pp. 372–375; prepared statement pp. 376–380)

Topic: Case Study: Legal Services to Nursing Home Residents.

The Legal Assistance Foundation ("LAF") is the legal services provider for the city of Chicago, but the Title III senior legal services provider is the Legal Aid Bureau of Chicago ("LAB"). Therefore, no conflicts of interest plague our organization because the Title III grant belongs to the LAB.

The LAF attempted to provide legal services to nursing home residents without an ombudsman program to back up the effort. Subsequently, the LAF filed, and recently settled, a lawsuit to ensure that nursing home residents in Chicago have an ombudsman program. The LAB/LAF experience illustrates that legal services cannot be provided to nursing home residents without an ombudsman program. (pp. 372; 376)

Prior to 1987, neither the LAF nor the LAB were providing any legal services to nursing home residents in Chicago. Nursing home residents would not come to either organization and often could use a phone to call a legal services lawyer. The LAB, at the request of the AAA, the Chicago Department on Aging, was providing legal services such as probate matters, consumer matters and some real estate matters. But no legal services were provided to nursing home residents.

The LAB identified this unmet need for legal services in nursing homes and obtained a grant from the Retirement Research Foundation to begin a legal outreach program to nursing home residents. The LAB maintained a physical presence at nursing homes speaking at resident council meetings and distributing literature on residents' rights. This outreach proved very successful as the residents voiced problems experienced everywhere, such as missing property, family problems, inquiries regarding trust funds, concerns over Medicaid eligibility and problems with nursing home staff. (pp. 372-373; 376-377)

The LAB has two lawyers assigned to the outreach program on a part-time basis for 1 year with ample support staff. In this effort, the lawyers are responsible for everything from reviewing trust fund records to discussing nursing care with families and directors of nursing homes to representing nursing home residents at discharge hearings. Resolving many of these problems is not an effective use of a lawyer's time.

On the other hand, LAB is too small to satisfy the demand for its services. Nursing home residents need someone to frequently visit the facility and to resolve their problems by cutting through the red tape. To reach more nursing homes, LAB contacted community legal services programs to discover how to provide legal services to nursing home residents. The overwhelming response encouraged LAB to develop an ombudsman program. A review of Title III revealed that Chicago nursing home residents are entitled to an ombudsman program. (pp. 373; 377)

LAB then found a person in the local area agency that was designated as the nursing home ombudsman. The problem was that this same person was also the head of Protective Services. She had a small staff, a small budget and maintained elder abuse as a priority. Her large case load precluded her visiting nursing homes on a regular basis. In addition, the State Department on Aging had issued standards for nursing homes, but were not enforcing them.

At the service level, people were too busy to take on the project. At the policy level, the legislators revealed that the concerns of nursing home residents were not a priority and that the limited time and money available should be invested in other programs. In this environment, the LAB filed a class action lawsuit on behalf of all the residents of Chicago nursing homes age 60 and over to enforce the ombudsman provision of the OAA. (pp. 374; 378)

The lawsuit was filed in May 1988 and a settlement was finally approved in March 1990. Before the lawsuit, the average Chicago nursing home had contact with the ombudsman program once every 2 years. The settlement calls for quarterly visits to nursing homes. Although other programs provide more fequent visits, the LAB experience illustrates that some improvements can be gained through litigation.

The settlement also provides for monthly visits to facilities that are subject to licensure revocation or decertification. With the settlement, LAB reached minimum staffing levels. Although this is still below the national average, LAB received two full-time employees in the Chicago ombudsman program. At the State level, an excellent training program has just been completed to implement the provisions of the settlement mandating training programs. Illinois has also allocated funds specifically for the ombudsman program.

The settlement contained provisions that referred directly to linkage between the ombudsman and legal services. One provision required the city to comply with the State requirement on minimum spending for programs. Another provision required the State to contract with the legal services provider to back-up the ombudsman program. Finally, the settlement contains a stipulation that the ombudsman staff, specifically the direct service staff, is to meet monthly with the legal services staff. (pp. 374; 378-379)

As a result of the 1987 OAA Amendments and the settlement of the lawsuit, Illinois passed ombudsman legislation. This legislation, which falls far short of the gains made in Ohio, constitutes a great step forward for Illinois. The reports for the Chicago ombudsman program for the first quarter of 1990 reveal that the staff made 104 visits to nursing homes, had almost 20,000 contacts with residents, and responded to 300 complaints. These changes in the Chicago ombudsman and legal services programs have meant substantial progress for the nursing home residents. (pp. 375; 379)

Mr. David Manley, Director of Litigation for the Legal Services of Arkansas. (pp. 381-383; prepared statement pp. 384-419; exhibits pp. 386-415)

Topic: Legal Services of Arkansas.

Prior to 1983, Arkansas did not have an organized program to provide legal services to the elderly. Presently, seven different programs provide the elderly with legal services throughout the State. But the elderly are treated like any other legal services client in that they must seek out the program and ask for assistance in resolving a particular legal problem.

By the end of 1983, Central Arkansas Legal Services program received some Title III money from the State agency to provide pro bono legal services to the elderly in Little Rock and central Arkansas. This program, which had already established a pro bono legal service through volunteer private attorneys, simply diverted the Title III money to help fund the provision of legal services to the elderly. (pp. 381; 385)

In late 1983, the young lawyers section of the Arkansas Bar Association decided to establish a pro bono program that serves only the elderly over 60 years old. Arkansas is second only to Florida for the highest percentage of elderly in the State population. The elderly are also some of the poorest people in the State. Consequently, the State Bar Association contacted the existing legal services programs and asked for assistance in establishing a program for the elderly.

The result of this collaboration was a 501(c)(3) nonprofit organization that now houses the legal services developer component of the State aging network. The board of directors of this corporation consists of the five legal services programs that help to fund it, five attorneys from the private bar appointed by the President of the Arkansas Bar Association, a potentially eligible client, and one representative of the State aging office. Currently, 544 attorneys participate in the program on a pro bono basis. These volunteer attorneys come from rural towns and have agreed to take three cases each year on behalf of the elderly. (pp. 382; 385)

In general, clients come to the program through referrals from the legal services network and from the local AAAs. A central problem facing this organization is that the legal services programs, which do not accept clients unless they are financially eligible, screen potential clients regarding their income before referring them. But the local AAAs are not allowed to screen individuals for income.

To maintain good public relations, the AAAs must be very careful whom they refer to the private bar for free representation. The problem arises when a referral from the AAA seeks free legal services from a member of the private bar but is quite capable of paying for such services. The general consensus throughout the legal services community is that the private bar is necessary to help provide legal services to the elderly. But the private bar must supplement the ongoing efforts of the legal services programs to visit nursing homes and identify elderly in need of individual services. (pp. 382; 387-388)

The legal services programs should also address systemic problems. Persons charged with handling these problems must be allowed to do their jobs, while the private bar should provide the individual services. Although the private bar can be effective in suing nursing homes to improve the care the residents receive, legal service programs address this issue every day and should continue to do so.

Arkansas has eight AAAs and in 1989 all eight sought a waiver to avoid having to provide legal services. Half received the waiver, while the remaining four AAAs allocated the following amounts to legal services: $25, $500, $5,120, $27,000. The $27,000 funded a full-time in-house attorney who handled only three cases.

The Act contains a very detailed statement of the mission for the ombudsman. But one person cannot do all that the Act calls for. The Massachusetts ombudsman program, providing weekly visits to nursing facilities, is very impressive. But that just is not possible with every program. Perhaps ombudsman programs should adopt the traditional role of the ombudsman to work within the system to effect changes. Ombudsmen in rural States cannot possibly perform all the tasks that the Act currently requires of them. (p. 383)

This tension between what ombudsmen are required to do and what they can do underscores the tension alluded to by Dr. Cohen between service work and impact work. The AAAs have not yet addressed the specific types of cases they need to be taking. If a particular problem occurs repeatedly, it does not make any sense to address each individual case. The appropriate course of action is to view the problem systemically and try to discover its root cause.

One issue that has yet to be discussed is the ombudsman's need for legal representation if sued. If the ombudsman is an attorney, he or she is in a better position than a lay volunteer who may not know what to do. An ombudsman who works in close conjunction with legal services programs or a Title III funded program is in an even better position to handle this problem. But how can the ombudsman program be structured to provide for the individual ombudsman who works alone and is the only person in the local agency? Many of the statistics cited in by the morning panelists reveal how much is not being done on behalf of the elderly. Clearly, no one is doing all that needs to be done. (p. 383)

Mr. Arnold Whedbee, Coordinator of Litigation, Advocacy and Training for Washington State's Evergreen Legal Services. (pp. 420–424; prepared statement pp. 425–442)

Topic: The Legal Services Corporation—an AAA Grantee.

This presentation will explore two broad topics: first, the legal services Title III(b) network in Washington State and the barriers it has confronted in recent years; and second, the developments in the Washington State ombudsman program and the potential link with legal services Title III(b) programs.

Provision of legal services to the elderly in Washington State began in 1975 or 1976 with the allocation of model project funding by the Director of the AAA. When legal services later became a priority under the Act, a system was already in place and some services were already provided to the elderly. Shortly thereafter, all of the AAAs in the State funded legal services.

This coordination of Title III and the legal services corporation has evolved over the last 15 years. Presently, two legal services corporation funded grantees account for about eight of the AAAs in the State. Gonzaga University Law School operates a clinical program using law students and supervising attorneys. Also, a private law firm has one of the AAA contracts. (p. 420)

A private bar panel is in place to serve the extremely rural areas of the State. In 1982 through 1984, the legal services programs were forced to close offices and reduce staff levels. But the network did not eliminate the AAA contracts in those areas subject to the cutbacks. Rather, the network administers those contracts through a panel of private attorneys. Although this method is not as efficient as some of the staff model programs, it has allowed for the continued provision of legal services to elderly in the rural areas.

The Title III(b) network allocates its funds primarily for the following issues: health care, housing, utilities, food, and adequate income. These issues encompass the array of legal problems which the network confronts. Parts of the network draft wills while other parts use lay advocates. But the bulk of the Title III(b) money is earmarked for the issues most important to the elderly, those of basic survival.

Two years ago, Ms. Hommel and the legal services staff from other States visited Washington State to discuss provision of legal services to the elderly. As a result of this dialogue, a number of changes in the Title III(b) network have been implemented. For example, quarterly meetings are now held with all the legal service providers, including Gonzaga Law School and the private attorneys, during which general issues, particular cases and effective strategies are discussed. (p. 421)

In addition, a second discussion with legal services staff took place last year aimed at developing standards for legal services. What kind of cases should a legal services network handle? What are the linkages with ombudsman programs? What types of reports could legal services staff provide and what types of reports will help AAAs in their planning and advocacy activities? The Title III(b) network provided a good framework within which to discuss these issues and suggest changes.

A third change in the network has been the frequent mailing of senior bulletins on a statewide basis identifying and explaining changes in Medicaid, the Copes program, VA benefits, etc. Some of the bulletins are formalized while others are no more than simple announcements. Presently, the bulletings are sent to about 300 people, but the audience is constantly increasing. The current list of recipients includes long-term care facilities, private attorneys, case managers and all of the Title III(b) providers. The bulletins help define the work the network is doing and focus the efforts of many people on the same complex issues. (p. 421)

In addition, the network has recently begun to interact much more frequently with elderly constituency groups. The senior lobby in Washington State, which has been existence for about 10 to 12 years, represents 22 elderly organizations throughout the State, including the Gray Panthers, retired union members and teachers, and retired government employees. These organizations raised issues which the Title III(b) network had never even considered.

For example, in the income area, the legal services network does considerable work with SSI payments. But the senior lobby raised an additional facet to this problem. From 1979 to 1989, while the COLAs were increasing at the Federal level, the Washington State supplement was decreasing from 89 percent of the poverty level to 79 percent of the poverty level. The senior lobby has sought legal analysis from the Title III(b) network in a number of areas such as this.

Most recently, the senior lobby worked for 2 years to pass an extremely comprehensive guardianship reform bill. At the same time, a staff attorney from the legal services network served on a task force sponsored by the State Bar Association to monitor the proposed legislation and provide comments to the bill. The senior lobby also wants to look at the elderly in the homeless population. It is very concerned about discrimination in the State mental health sysstem. As a result of the legal services network's interaction with the senior lobby, advocacy has improved.

Although funding sources often do not approve of certain activities in which a State aging network might engage, the efforts of the Washington State legal services network receives wider support because of its link with the senior lobby, which represents a significant number of the State's residents and is concerned about the same issues. In the last 2 years, the State legislature has also taken steps to facilitate the linkage of legal services programs with long-term care ombudsman programs. (pp. 421–422)

Last year, the legislature placed the ombudsman in a new State government agency and required that it be contracted out to a nonprofit organization. Second, in the last legislative session, $75,000 was earmarked solely to ensure adequate legal assistance to both residents of long-term care facilities and to staff of the legal services program. Finally, the ombudsman budget increased from about $200,000 a biennium to about $660,000 a biennium in response to the efforts of senior groups, resident councils, etc. Although adequate funding levels have not yet been reached, great progress has been made in that direction.

Presently, the State legal services network's basic grant represents only 14 percent Title III dollars. The remainder comes from State money. The legal services network looks to the ombudsman program to identify the problems in the State's long-term care facilities. Ombudsmen should attempt to resolve those problems to the greatest extent possible through the use of volunteers and other resources. They should also determine the appropriate point at which to seek out an attorney's assistance. The legal option should be pursued after exhausting the other possible remedies, including referral of the problem to a regulatory agency. At that point, the legal services program will help resolve those cases that resist easier settlements. (p. 423)

For example, the legal services network and the ombudsman program are currently working on a case that the State Attorney General tried and lost. The case involves Lady A who advertises services for the elderly. People call in and she tells them of Lady B who does a contract for $1,200 or $1,300 per month. Lady A, who has rented a house for service to elderly residents, does a contract for $600 per month to provide services. The team makes $10,000 to $12,000 per month by providing services to the five to seven elderly persons who take up residence in the house.

The Attorney General's failure to shut down this house means that this arrangement has survived the State's family home laws and boarding home laws. Potential legislative solutions, which could not take effect until January, are the only options left given the failure of the judicial alternatives.

The legal services network has also taken on a couple of guardianship cases where people have been placed in residential settings against their will, either under a durable power of attorney or a guardianship. State law provides that even if a person has a guardian, a mental commitment proceeding is required before placing the person in a nursing home or residential treatment setting against their will. This has been the focus of the litigation undertaken by the legal services provides in the guardianship area. (p. 419)

Ms. Penelope A. Hommel, Executive Director of the Center for Social Gerontology. (pp. 443–448; prepared statement pp. 449–451)

Topic: AAA Oversight of Legal Services and Data That Should Be Collected With Respect to Legal Services.

Before addressing these two topics, some general observations about legal services are suggested by the Social Gerontology Center's "Center" work as a national support center in law and aging. Over the years, Congress has increasingly recognized the importance of legal services, viewing it as an access service ensuring the elderly access to critical public benefits, adequate housing and proper nursing home care. The first evidence of Congressional emphasis upon legal services came in 1975 with the designation of legal services as one of four priority services under the OAA.

In 1978, this priority was strengthened by the requirement that some funds be spent on each of the priority services. In 1981, further emphasis upon legal services was evidenced by the call for not merely some funds, but an adequate proportion of funds to be spent on legal services. In 1984, the waiver provisions were strengthened. To avoid spending money specifically upon legal services, AAAs now had to demonstrate that the need for legal services was already satisfied. Finally, the most recent amendments to the Act in 1987 required every State to set a minimum percentage of Title III(b) funds to be spent by each AAA on legal services. The waiver provisions are tied to this mimimum percentage. (p. 444)

Increased recognition of the value and impact of legal services for the elderly has been the trend in recent years. As a result, a number of excellent legal services programs have emerged like those in Washington, Illinois and Arkansas. But with many State agencies and AAAs, legal services remain seriously underfunded. The minimum percentages set by the States in accord with the 1987 amendments range from 11 percent in Washington State down to 1 percent in other States. Even in those States with a 1 percent requirement, a number of AAAs still obtain waivers. Absent a waiver, an AAAs compliance with the 1 percent requirement translates into real dollars of less than $1,000 per year for legal services. A few States have yet to even set a minimum percentage as the Act now requires. (p. 444)

A related problem is the maintenance of the effort by AAAs to provide legal services. In those States where the AAAs fund legal services at a higher level than the State percentage requires, the AAAs have the option to reduce the level of funding for legal services if there is no requirement to maintain the current level. Thus, in spite of the Congressional priority on legal services, the major barrier to effective provisions of legal services remains funding.

An equally important barrier is the lack of understanding within the aging network of the potentially broad contributions that legal services can make to the problems of older persons. Without good programs to perform outreach activities, to educate people to recognize their problems as legal problems, to emphasize community education, and to target important issues, then there tends to be no demand for legal services. (p. 444)

Often, ombudsmen and legal services needs assessments are inadequate and the elderly do not recognize they have legal problems which need a legal remedy. Even if the elderly were educated to recognize their legal problems, there is still no demand for legal services if a good legal services program is not in place. In this way, funders of services continue to lack an understanding of the importance of legal services.

To overcome this barrier, programs must be established to do outreach to those groups that have been targeted as having the most serious problems which can be addressed through legal services. This requires outreach beyond nutrition programs in the senior centers to include churches, migrant centers, and wherever else a particular target group can be found. The programs discussed previously in this workshop offer excellent examples of successful targeting by legal services programs. (pp. 444–445)

Similarly, efforts at community education must also be targeted to particular issues and particular groups. Some of the more important groups, in the context of ombudsmen and legal services, are nursing home residents and board and care residents. Additional groups currently being targeted include the homeless, the abused and neglected elderly, and persons at risk of guardianship.

In addition, programs have been established to perform impact work, which is essential to convincing the AAAs and State agencies of the importance of legal services. These programs do not simply address repeat problems on an individual level. Rather, they look at the systemic problems and take on cases and related activities that will change the system. The existence of these programs helps generate support for legal services programs. (pp. 445–446)

But where these programs do not exist, the barrier of failing to recognize legal problems makes it very difficult to establish good programs and obtain adequate funding levels. To resolve this problem, more statewide leadership, coordination, and education are required. When a successful program is in place in one part of the State, AAAs in other parts of the State should be educated about the program and the importance of the program for the elderly.

The lack of an understanding about the contribution that legal services can make is accompanied by a lack of an understanding about what is a quality legal problem. Our Center currently visits different states to help develop statewide standards for legal services. In the last 2 years, however, the Center visited 25 States simply to work on the problems identified by the AAAs and State agencies at the level at which legal services are developed. (p. 446)

The advice most often given to the AAAs is to contract for a legal program rather than simply buy a lawyer or paralegal's time. Many AAAs are meeting the minimum percentage requirements, but they are spending the allotted funds on an individual contract with a lawyer or paralegal to provide the needed services. These AAAs fail to consider developing a program, including outreach, targeting, and community education.

Even in those areas where the funding level is less than $1,000, the provider still finds it difficult to properly spend the money. Without a program in place, the only alternative is to simply contract for an attorney or a paralegal's time which means that those persons who walk in the door receive legal services. These persons most often seek assistance with wills and estate planning since these are the issues that the elderly tend to identify as legal problems. But even these few walk-in clients would not know where to seek legal services if there were no outreach effort or if the available services were not easily accessible and visible to the elderly community. (pp. 445–446)

These observations regarding legal services suggest a few specific recommendations for the reauthorization of the OAA. A separate title should be included in the Act for advocacy services, both ombudsman and legal services. Then, money should be allocated for this new title in order to make quality legal services programs possible on the State and area level.

Congress should also strengthen the Act's mandate on the State agency to provide leadership and training in the development of legal services. The Center's visits to the various States involve working with the respective State's legal services developer, if there is a developer on staff. In those States where there are developers on staff, they may only be able to spend 20 to 30 percent of their time on legal services. The remainder of their time must be spent on a wide array of other activities. Absent statewide coordination, training, and uniform standards that specify what is expected of legal services providers, this serious barrier to effective advocacy will continue. (p. 446)

Third, Congress, rather than the States, should set the minimum percentage funding level for legal services. But Congress should also set a minimum dollar amount and hold the States responsible for the higher of the two figures rather than simply setting a minimum percentage which could translate into very few real dollars. Further, these percentage and dollar levels should be linked to the percentage and dollar levels spent upon the other two priorities which Congress has consistently maintained since 1978, namely access and in-home services. The percentages spent on these latter priorities are substantially higher than what is being spent, and what is being required, for legal services.

In addition, a system should be developed for statewide reporting that includes more than simply units of service, numbers of units delivered and dollars spent. Such information is not very useful. Obviously, legal services are an expensive type of service so that the numbers of persons served and the numbers of units of service will be lower than those of other Title III programs in terms of dollars spent per unit.

A more useful reporting system would look beyond the mere units of service and would try to assess the impact of legal services. One simple mechanism is to calculate the dollar benefits for clients of legal services. Another possibility would be to measure the impact of legal services upon maintaining the independence or dignity of older persons through reports of postponed evictions, avoided guardianships, etc. In this way, the true impact on the elderly of intervention by legal services can properly be assessed. (pp. 447; 450–451)

PARTICIPATION FROM THE AUDIENCE

Ms. Nancy Coleman, Director of the American Bar Association's Commission on Legal Problems of the Elderly:

It is amazing that the popular press raises the legal issues and the legal awareness of the American public. Our organization collaborated with Ann Landers and AARP in March to advertise a booklet containing information on health care powers of attorney. One hundred and twenty thousand people wrote to AARP for a free copy within 1 month. As the issue of public awareness is raised in the context of the OAA, we must be aware of the type of information provided by the popular press and other sources like television programs. (p. 453)

For example, to simply advise an older person to seek out a lawyer for help with a particular problem is inadequate. Ann Landers and other such sources fail to tell people needing help to seek out a Title III attorney, or find a legal services corporation attorney, or approach the Bar Association, etc. The situation is that the American public, specifically the older population, is not aware of the variety of delivery systems available.

If people could find the local AAA in their yellow pages, then they might encounter the Title III lawyer. But if a person seeks assistance with her will from the Evergreen Legal Services program, one of the finest in the Nation, she will not receive the kind of help she needs. She might be successful if she calls the Title III program in Arkansas and gets referred to the proper pro bono attorney, but there are many steps that need to be taken in that process. (p. 454)

The problem posed is really one of determining what the people are asking for and then to integrate that question with the public sources of information that raise legal awareness. Is a particular person really asking for a will, or is she asking for a division of property, or is the request for something even more subtle such as legal planning? (p. 454)

Mr. **Sushil Sharma**. It is true that there is a wide range of services that is currently offered to the elderly. The question is how to resolve the problems that we experience. The solution is to supply the legal arena with more ombudsmen, legal advocates, and regulations.

What are the moral responsibilities for the providers of services to the elderly? Why are the elderly in the predicament they face? These questions must be addressed, considering that by the year 2000 more than 4 million people will be over 100 years old. These persons will require increasing levels of assistance. Before these persons seek legal services, what factors precipitate the need for legal services and who are the other actors in the service system? (p. 454)

The special quality of the OAA is that it speaks to the quality of life for older Americans. A wide range of services are offered under the Act. A number of social service providers are available to those individuals who are supposed to make frequent visits to nursing homes and board and care facilities.

But what is the link between the social service provider and the legal service provider? If the purpose of the Act is to coordinate these services, how is this being achieved? How is information of abuse and neglect in the various facilities being disseminated to the public? Is it through the popular press or through more formal channels such as the AAA or AOA? Is the system working? (pp. 455)

Mr. **Manley**. These concerns were addressed in Arkansas, though possibly they have yet to be resolved. The Act requires that legal assistance be provided by an attorney or someone who is supervised by an attorney. The problem is that no matter who visits the facilities, most elderly do not know if the problem they face is a legal problem. Is the stopping of their social security checks a legal program or a bureaucratic problem?

If non-lawyers visit the facilities to talk with the residents, they may be unaware that an attorney could be helpful in resolving reported problems. But if the non-lawyer could report back to an attorney, then the attorney could assess the problems to identify them as legal, social or bureaucratic problems. In this way, it is unnecessary to have attorneys visit each nursing home on a weekly basis.

Unfortunately, many restrictions limit what can be done. It is not feasible to advertise available legal services. The private bar is precluded from doing so. In a perfect society, ombudsmen would be unnecessary if a nursing home were doing its job. But ombudsmen are needed. If just is not clear whether this is a legal, social, or moral problem. (p. 455)

Dr. COHEN. Ombudsman and legal services programs should discuss with HCFA staff, with the State health departments, and with the elderly and their relatives to determine what really constitutes first rate nursing home care for those who need it. This dialogue should ignore what the law requires for nursing home care. Once this discussion takes place, then it will be apparent what the law can accomplish and what progress must be obtained through other means.

This initial step has been overlooked. The current approach to assessing nursing home care simply relies upon certain quantitative factors, such as the number of staff time hours for patients. If the sum total of these factors reaches a certain level, then the nursing home provides good care. This assessment is necessary, but it is insufficient. Even if every requirement of OBRA and the Institute of Medicine were met, that would still be insufficient. (p. 456)

To gain an understanding of what is really desired of the nursing home profession, an effort must be made at beginning an open discussion about nursing care. What is to be expected of a director of nurses? What should a nursing home look like and sound like? What are the goals of nursing home care and what happens if these goals are attained? Once these questions are resolved, how is this vision imparted to directors of nurses, to OTs, PTs, administrators, aides, etc.?

A great deal has yet to be done. But the changes that are necessary are changes of moral goals. Legal tools and legal services are important, but they are not ends in themselves. (p. 455)

Mr. James Bergman, Executive Director of the New Jersey Health Ways Foundation:

Today's discussion deals with barriers to effective advocacy, especially legal advocacy. These barriers exist because legal services have never been considered an integral part of the aging network. Services such as transportation and in-home services are self-evident. But most people in the AAAs and State agencies do not have a strong sense of what legal services are. As a result, when Title III funds are disbursed, the bulk goes to transportation and in-home services while very little goes to legal services.

The failure here is shared by the lawyers and the AAAs equally. The AAAs are not interested in finding out what legal services means. But lawyers have failed to communicate clearly and accurately what services lawyers provide. Lawyers must help the AAAs and the general public to view legal services as the protection of an individual's rights. As Dr. Cohen correctly stated, legislation cannot accomplish this. (p. 457)

AAAs need to build this idea into their area planning process. The problems indentified in the area planning process need to involve the legal program. The contracted legal services should emerge directly from this planning process. For example, if the decision is made to address nursing home problems or guardianship problems, then the legal program should be funded to focus on that issue and be a part of the AAA's thrust to address the issue.

Some provision of direct services should continue. But these public benefits should be viewed as a legal program and not isolated legal services. The Massachusetts legal services program attained its current level of productivity through a close working relationship with the AAAs. The local legal services programs worked together as well. This effort was not designed to promote legal services but advocacy. As soon as this cooperation began, the awarding of grants began and an elderly legal coalition was formed. All advocates in the State, not just the lawyers and the AAAs, saw this as an opportunity to focus upon advocacy.

In the reauthorization process, a great deal of additional language is not necessary. A waiver should be made almost impossible to obtain because no one is meeting the needs that currently exist. Perhaps a better approach would be to view this effort as advocacy and to include a separate title that deals specifically with advocacy. Alternatively, area plans could be required to have an advocacy portion within which would be the legal services program and the other advocacy efforts of the AAA. This would be the best way to integrate legal services into the overall Title III aging network. (p. 458)

Ms. **Fisher**. Our local AAA recently received additional funds and solicited comments on how to spend it. The priorities identified included income maintenance, health care, and maintaining homes for the elderly. But the AAA never considered the possibility that legal services had any bearing on these priorities. This is very frustrating, especially when the legal services program performs large amounts of income maintenance and health care work. (pp. 458–459)

Mr. **Manley**. The available literature fails to provide statistics about what kind of legal services the elderly need. In an Arkansas survey, 14,000 elderly people identified their top priority as legal services. Although this is not a large number of people given Arkansas' population, it is a large number of people to believe they have a legal problem. Some statistical measurement must be developed to impress upon people the profound yet unmet need for legal services. (p. 459)

Ms. **Holder**. The nursing home reform law is built upon the concerns expressed by residents and family members for the last 15 years. Also, our organization conducted the very discussions suggested with nursing home residents throughout the country. A report of these discussions was submitted to the Institute of Medicine reflecting what residents seek from nursing homes, the ombudsman program, etc. Others have conducted followup to this initial work. Even if this report is a quasi-public record, the new reform law expresses the standard for good nursing home care based upon good care practices observed in nursing homes for many years.

The public policy behind this law is outstanding except for minor gaps that need to be addressed. The ombudsman program, and its presence on a daily or weekly basis, will be critical to implementing the reform law. Legal services will also become involved at different points in the law's implementation. The programs discussed in today's workshop will be a great part of the law's success. Support for the ombudsman programs and legal services, as well as for any measures that will strengthen existing programs, is essential. (pp. 459-460)

Mr. Alfred Chiplin, Staff Attorney for the National Senior Citizens Law Center, Washington, D.C. Office.

The OAA does not contain any provision for an individual to exercise a private right of action with respect to any of the Act's principles. Although this is a controversial issue, this seems the best time to discuss the possibility of such a provision. All the other statutes, which consider the merging of ethical and legal issues, provide individuals with the opportunity to exercise their rights.

The reauthorization process should consider various methods that might allow for this kind of individual input. The last reauthorization of the OAA raised this issue unsuccessfully. But the entire discussion of law and ethics, the philosophy of how people move society, is valueless if the individuals cannot initiate the process. (p. 460)

Ms. Norma Pinkleton, Director of the Gerontological Nurse Practitioner Program.

Our program includes legal services as well as an ombudsman. But in speaking about coordination and quality of care, the issue of manpower and its cost must not be forgotten. This is a big issue which is difficult to address from a variety of perspectives. For example, salaries and costs of manpower are one issue, but that is directly tied to the ability of the staff to understand the need of clients and refer them appropriately. Nurses and other properly trained personnel are capable of performing this function.

Additionally, it would be helpful to know how the new nursing home regulations that are due in October can be accessed now so that they can be integrated into different educational programs. (pp. 460-461)

Mr. Bill Benson, Head of Staff for the Subcommittee on Aging of the Labor and Human Resources Committee.

The following two legal services questions are addressed to the entire panel. First, the Special Committee on Aging, in conjunction with the National Senior Citizens Law Center, conducted a survey of legal services programs throughout the country. Although the results are still only preliminary, the most striking information involves the types of cases these programs handle. According to the survey, "the four most common types of cases are consumer protection, housing, advance directives, meaning durable power of attorney and living wills, and estate and probate matters." This does not include what logically would be the most common type of case, namely public entitlements such as Social Security, Medicaid, Medicare, disability, etc. Perhaps this reflects a flaw in the service system or rather a change in societal concerns.

Second, can the funding programs to provide non-lawyer advocacy, without an attorney on-site or behind the scenes, be deemed legal assistance or legal services? Is anyone in the country advancing this argument? Would such a program constitute legal assistance? (p. 461)

Mr. **Whedbee**. The cases handled by the Evergreen Legal Services program are provided in the program's literature. It handles housing cases (19 percent), health matters (35 percent), guardianship cases (10 percent), public entitlements (14 percent), and consumer cases (8 percent). (pp. 461–462)

Ms. **Hommel**. The types of cases reported in the survey are not all that surprising. It relates back to the point raised earlier regarding the difference between contracting for a lawyer and contracting for a legal services program.

Two trends seem to emerge from this survey. First, there is a strong development of programs with a broad view of advocacy and the role of legal services in an advocacy effort. The Evergreen legal services program is a good example. This is the product of a significant level of funding that allows the program to work with AAAs, other service providers and advocacy groups. These people are able to identify the issues that are most important and focus their energies on these issues.

Second, in areas that have not had good programs in the past nor successful efforts at providing legal services, the trend is to fund private attorneys, usually sole practitioners, and to fund just a small portion of that attorney's time. Consequently, the attorney simply handles those cases that walk through the door.

The resources and time do not exist to perform outreach and community education. Pressing issues cannot be identified because there is no collaboration between the individual attorney and other service providers. Absent this, the people who do walk through the door will not know what type of legal assistance they need. They might not seek out a lawyer at all because they might not identify their problem as a legal problem. This trend toward contracting with a private practitioner as opposed to a program is a significant problem. (p. 462)

Ms. **Fisher**. In the last 10 years, Title III legal services providers have changed dramatically. Legal services corporation grantees once comprised 75 percent of all Title III service providers. Presently, close to 50 percent of the providers contracted are private attorneys.

The contracts often do not specify what services are to be provided, but rather are based on the number of hours of service. A private attorney could contract with an agency for $5,000 and then simply set a fee for particular services, such as $75 for a will. No uniform standard is set. Who is the service provider and what are the services being provided? These questions arise with the shift from the publicly funded legal services program under Title III to a private attorney. (pp. 462–463)

Mr. COHEN. In a claim-based society, one in which service providers rely on people coming through the door with a complaint, nobody takes action until a complaint is made. In addition, nonlawyers may see a problem, but it is not important whether they identify it as a legal problem. Consumers cannot be expected to identify the legal problem either.

Some mechanism should be developed to talk with the elderly, to see if a legal problem exists and then, to call in a lawyer to discuss the appropriate course of action. More effort must be made at establishing a connection with the elderly population. Those involved with the coalition for nursing home reform have been accumulating this kind of information and know how to elicit what people sense as a problem. They have also begun to collaborate with legal services attorneys to develop legal remedies where appropriate. (p. 463)

Ms. Jane Harden, Legal Council for the Elderly of AARP: According to a survey conducted by our office, elderly people needed most help with Medicare bills which are frequently fact intensive bureacuratic problems and not appropriate cases for legal services lawyers.

A pilot project in Pennsylvania utilizes lay advocates to work with the elderly. The cases are then reviewed by attorneys to determine which cases have legal aspects, which can be appealed, and which reveal systemic problems that should be subject to legislative reform. Currently being discussed is the possibility of using lay advocates without legal supervision if they would comply to tighter restrictions from the legal services programs. (pp. 463–464)

Mr. John Monahan, Senate Special Committee on Aging: To clarify how the survey was conducted, each of the 50 State offices received a series of questions about the Title III services within those States. At present, 29 States have responded to the survey. Many of the State offices in answering the survey relied not only upon the data they had collected but also contacted some of the local programs directly. Although not every Title III legal services provider was contacted, the survey does provide a good cross section of how the money is being spent. (p. 464)

Mr. WHEDBEE. The case management system utilized in Washington State for the last 10 years, which evolved from an information and referral system, has trained people in how to do Medicare billing and how to calculate who are the medically needy. Title III(b) dollars need not be spent on this particular activity.

The services that will be provided obviously depend on the ultimate decision of what activities will be funded. If the program wants to provide representation for those people in nursing homes, then the funding of a lay advocate is inappropriate. To protect the rights of these people, lawyers must represent them since those persons on the other side of the issue will be well represented by lawyers themselves.

But if it is decided that the best way to help these people is to change certain laws through legislative channels, these residents should be represented by lobbyists, rather than a lay advocate. In short, the needs to be addressed must clearly be defined before a program can properly decide on whom the limited funding available will be better spent. (pp. 464–465)

LEGISLATIVE RECOMMENDATIONS

PANEL I: OMBUDSMAN SERVICES

1. The current formula for allocation of funding is inadequate. A more thorough study should be performed before any changes in the current program are made. State ombudsmen should collaborate with AOA and Congressional analysts to develop a formula for the distribution of Federal funds. (p. 53)

2. To offset manpower shortages, novel and creative staffing models should be adopted. The potential for growth of the program rests in finding a proper use for volunteers. (p. 54)

3. The need for a long-term solution, rather than a case-by-case approach, increases as the number of cognitively impaired residents grows, residents particularly vulnerable to various abuses. Intensive training is needed on the local level as well as a greater focus upon statewide policies and standards. (p. 54)

4. A specific remedy, such as carefully drafted enabling legislation, is essential if the local ombudsman is to be an effective representative and advocate. (p. 56)

5. The Act must clearly permit disclosure of a complainant's identity without consent if the resident's life or safety is in serious danger as a result of abuse or neglect. (p. 58)

6. Ombudsman programs must expand to provide at least monthly visitation to nursing homes in their respective areas. (p. 59)

7. Prior to placing any further mandates on ombudsman, the GAO and the Inspector General should conduct a review of the existing program models in the country. Expansion of the long-term care ombudsman program should not come at the expense of the facility residents. (p. 59)

8. Any recommendations for change in the current system cannot reduce the current level of service upon which so many elderly rely. (p. 59)

9. The Act should define ombudsman services as a priority for AAAs. (p. 59)

10. The Act should specify a separate funding process and establish a level for funds that do not place long-term care ombudsman services in competition with other community-based services. (p. 59)

11. Residents of nursing homes and board and care facilities should have access to all elder services, such as transportation and legal services. (p. 59)

12. The AOA should be required to conduct an in-depth study of the effectivenes of the present ombudsman programs and to require corrective action in States determined to be out of compliance with the OAA. (p. 59)

13. The Act should describe the necessary components of an ombudsman annual report to ensure a proper focus on the important issues. (p. 59)

14. The OAA should define regular visitation and emphasize the importance of services to board and care residents. (p. 59)

15. Funding of the National Resource Center should continue under the OAA. (p. 59)

16. There need to be stronger ties between the ombudsman program and the legal services network funded under Title III. Neither understands the other's priorities. This is one of the most critical issues for the 1990's. (pp. 60–61)

17. The confidentiality provisions of the Act should be strengthened and clarified. (p. 61)

18. The back-up centers for the ombudsman programs, especially the national back-up centers, should have increased funding to perform their vital functions. (p. 61)

19. Additional funding should be provided to the national legal services back-up centers which provide invaluable support for legal advocacy for nursing home residents. (p. 61)

20. Matching grants for home care ombudsman should be provided through the OAA to encourage State General Assemblies to separately fund home care ombudsman activities. This would avoid burdening ombudsman programs with additional mandates without increased revenue. (p. 61)

21. A separate Title should be added to the OAA to fund the advocacy services provided through both ombudsman programs and legal services. (p. 61)

22. An adequate funding formula or needs assessment should be developed to address the concerns of legal services and ombudsman programs. (p. 62)

23. A national organization of volunteer ombudsman should be created to prompt discussion of volunteering and investing money in those activities for which ombudsman are necessary. (p. 63)

24. A working relationship must be developed between the ombudsman program and the State certification agency to help provide the necessary direction from the State level. (p. 66)

LUNCHEON PRESENTATION

1. Those involved in legal services programs should begin to provide comprehensive services. Legal advocates should perform the public relations, the legislation analysis, and draft the press releases. (p. 68)

2. The reauthorization of the OAA should be viewed as an opportunity to explore some different models and advocacy strategies. (p. 69)

3. The power of moral obligation, and the role of government in enhancing the sense of moral obligation, should be considered. (pp. 65–66)

4. System reform should be considered as important as the current case-by-case approach to complaint resolution. (p. 69)

5. Any provision of the OAA, when considered during the reauthorization process, should be considered in the context of Title I. (p. 69)

6. To overcome the barriers to systemtic reform, the programs will have to be given independence form their respective funding sources. (p. 69)

PANEL II: LEGAL SERVICES

1. A separate title should be included in the Act for advocacy services, both ombudsman and legal services. (p. 78)

2. Money should be allocated for this new title in order to make quality legal services programs possible at the State and local level. (p. 78)

3. Congress should strengthen the Act's mandate on the State agency to provide leadership and training in the development of legal services. (p. 78)

4. Congress, rather than the States, should set the minimum percentage funding level for legal services. Congress should also set a minimum dollar amount and hold the States responsible for the higher of the two figures. A minimum percentage could translate into very few real dollars. (p. 78)

5. New percentage and dollar levels should be linked to the percentage and dollar levels spent upon access and in-home services. (p. 78)

6. A system should be developed for statewide reporting that includes more than simply units of service, numbers of units delivered and dollars spent. A more useful reporting system would try to assess the impact of legal services on the elderly. (p. 78)

7. The Act should establish programs to perform outreach to targeted groups. These groups are those with the most serious problems that could be resolved through legal means. (p. 76)

8. Similar efforts at community education should be targeted at particular issues and particular groups. (p. 76)

9. Greater statewide leadership and coordination should be mandated in the Act. A State should educate the AAA's about successful local programs operating throughout the State. (p. 77)

10. The reauthorization process does not require the extensive drafting of new language. The Act contains most of the necessary provisions, but they need to be given force. (p. 81)

11. A waiver should be made virtually impossible to obtain given the needs that are currently not being met. (p. 81)

12. If a separate title for advocacy is not added, the Act should simply require area plans to have an advocacy section within which would be found the legal services program and the other advocacy efforts of the AAA. (p. 81)

13. Congress should consider various possibilities for providing individuals with a private right of action under the OAA. (p. 82)

SUMMARY OF WORKSHOP IV

REAUTHORIZATION OF THE OLDER AMERICANS ACT

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

WASHINGTON, D.C.

OCTOBER 18, 1990

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INTRODUCTION

In anticipation of next year's reauthorization of the Older Americans Act ("the OAA" and "the Act"), the U.S. Senate Special Committee on Aging, in conjunction with the General Accounting Office (GAO), conducted four workshops in 1990 to examine the efficacy of the Act in its present form and to consider legislative options for improving the social services offered to elderly Americans. Since 1965, the Act has authorized many diverse and important services and programs, including nutrition, employment, advocacy, information and referral, etc. This is the fourth in the series of informal workshops to examine whether the Act remains appropriate for the needs of the elderly in the 1990's.

This workshop considers administrative implementation of the OAA and the role of the Administration on Aging ("AOA"). A panel of experts addressed each of these issues. An informal discussion between the speakers and the audience followed the panelists' presentations. The following summary describes the workshop proceedings, tracing questions raised, issues discussed and options proposed for amending the OAA.

SUMMARY

MODERATOR'S OPENING REMARKS

Mr. James Musselwhite, GAO. (pp. 492, 499–500)*

This is the fourth and final informal workshop on the reauthorization of the OAA. The first provided an overview of the OAA, specifically dealing with the issues of targeting and gap-filling. The second workshop considered information and referral systems and information sharing within the aging network. The third workshop explored the efficacy of ombudsman programs and legal assistance for the elderly. This workshop will focus upon administrative implementation of the OAA and the role of the AOA.

These workshops reflect the strategy of the Senate Special Committee on Aging to collect information that will assist Congress in the reauthorization process. This year marks the 25th Anniversary of the OAA's services to the Nation's elderly. Over the last decade, the elderly population has increased rapidly and will continue to do so. Currently, approximately 32 million persons are 65 years old or over. The old old population is increasing even more dramatically. (p. 492)

The Act's budget is approximately $1.2 billion, $750 million of which is administered by the AOA. Most of this funding is Title III dollars that the States receive in the form of grants. In response to the growing elderly population, program and service development has increased in the last decade at the Federal, State, and local levels and in the private sector as well. Many of today's speakers will address this change in the service environment in which the AOA functions. How can the Act be improved and the role of the AOA strengthened in the 1990's? (p. 496)

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*Reference is to the applicable pages where the full text of the Workshop IV transcript appears.

PANELIST PRESENTATIONS

Ms. Carol Crecy, Acting Deputy Associate Commissioner for State and Community Programs, Administration of Aging. (pp. 500-513)

Topic: AOA Activities.

The AOA performs an important analytical and educational role. The AOA's 1990 discretionary funds program continues its emphasis on education and training from previous years. Title IV funds were awarded to State and area agencies in priority areas such as training and technical assistance. Collaborative efforts with the private sector and curriculum development projects between State education departments and State agencies received funding. In addition, the 1990 Title IV program supports projects across a wide range of manpower development concerns, including faculty and program development. Finally, support for the minority management training program has continued throughout this reauthorization period. (pp. 500; 504-505)

The AOA occupies an important position within the Department of Health and Human Services. Since the passage of the 1987 amendments to the OAA, the Commissioner on Aging has reported directly to the Secretary of the Department regarding all policy matters. In addition, the Commissioner, as a member of the Secretary's senior staff, regularly attends the Secretary's senior staff meetings.

Administrative services are provided to the AOA by the Office of Human Development Services. The Commissioner's ability to discuss policy matters relating to the elderly with the Secretary and other operating divisions of the Department provides invaluable assistance to AOA in carrying out its Title II responsibilities. (pp. 500-501; 505)

The AOA also provides technical assistance to State agencies and area agencies through a variety of measures, including the provison of direct technical assistance by the AOA's 10 regional offices. The Commissioner meets frequently with representatives of State and area agencies to determine additional ways in which the AOA can be of assistance. The Commissioner has stressed continuous dialog and communication with all members of the entire aging network to insure that the AOA's technical assistance efforts are directed toward meeting the most important needs of the elderly.

In addition, AOA makes extensive use of its Title IV resources to develop and extend technical assistance and training to those at the State and community levels responsible for planning, providing, and evaluating services to older persons. Title IV funds have been used to support leadership institutes, resource centers, and other activities which include the provision of technical assistance and training as a major component of their respective programs.

The aging network still requires additional training and technical assistance on information and referral. AOA recently funded a major effort to strengthen information and referral services, increase the professonalism of these services, and establish quality standards for implementation. (pp. 501; 505–510)

Presently, AOA continues its efforts to improve efficiency, coordination and dissemination of data. In recent years, AOA has placed increasing emphasis upon the improvement of program data collection and upon the dissemination of data for nationwide planning development. Implementation of improved methods of data collection temporarily stalled the collection of new data. Consequently, only first year data has been collected. Gaps in the data and numerous problems with the data collection instrument have already been identified.

As a result, the Commissioner is establishing a task force of State and area agency representatives to evaluate the current form of data collected, to review suggested improvements, and to make recommendations for improving the quality and compatibility of data submitted by the States. While this marks extremely important progress in redefining the data collection process, the aging network urges caution in effecting revisions of the collection instrument. AOA intends to continue the process of revision through appropriate consultation with those groups from whom the data will be collected in coordination with other Federal agencies. The Commissioner also seeks to improve coordination with other Federal agencies. In addition to affecting numerous inter- and intraagency agreements and memoranda of understanding, the Commissioner has initiated an inter-departmental task force on aging. The purpose of the task force is to identify issues for policy and program coordination and to develop collaborative interdepartmental approaches in preparation for the changing and growing aged population. (pp. 502; 510–511)

Further, AOA engages in numerous activities which address the requirements of Title II. These activities include the provision of technical assistance, the collection and dissemination of data on aging, advocacy for older persons, aging services programs within the Department of Health and Human Services and with other Executive agencies, and program coordination. Within the framework of AOA's annual goals, Title II is the primary focus.

For example, AOA recently established a private sector management committee to increase awareneness of the challenges of changing committee to increase awareness of the challenges of changing demographics and to stimulate the expansion of services and resources for older persons by promoting and expanding public/private partnerships. The responsibilities assigned to AOA and the Commissioner under Title II convey a broad mandate for the agency to provide aggressive leadership in the aging field.

In summary, AOA has taken, and will continue to take, timely action to fulfill the requirements of the 1987 amendments and to carry out the intent of Congress. The OAA has been very successful in serving the Nation's elderly. The 1987 amendments made the Act even more effective in meeting the needs of a growing population of older Americans. (pp. 502; 513)

Mr. Herb Sanderson, Director, Division of Aging and Adult Services, Little Rock, Arkansas. (pp. 514–516; prepared statement pp. 517–519)

Topic: The State Agency Perspective.

From the perspective of the Arkansas State agency on aging, AOA is not a position to perform its analytical and educational role nor does AOA provide sufficient technical assistance to the State and area aging units. In recent years, a loss of staff has diminished the capacity of AOA to fulfill these mandates. The Committee or the GAO should assess AOA's capacity to perform its vital functions as the elderly population increases and staffing budgets decrease. (pp. 514; 517)

AOA should have technical experts and specialists to assist the State and areas agencies. AOA should not become an overpowering bureaucracy that simply generates paperwork. Although much of the current technical assistance to State agencies and AAAs is provided through discretionary grants, these grants have a number of drawbacks.

Once a grant is completed, AOA does not have the residual capacity to retain the expertise provided through the grant. For example, the long-term care centers that once existed are no longer funded. In Arkansas, the people that benefitted from these centers are gone. These centers may have survived in other regions, but our region lost the expertise gained over the years when the long-term care centers prospered. In addition, sparse travel funds limit the ability of the regional program directors to visit particular State agencies at the invitation of a State director.

To remedy these problems, the OAA should include language that gives the Commissioner complete authority over the salary and expense budget to adequately administer AOA. Presently, the Commissioner does not control the salary and travel budget appropriated to her. (pp. 515; 517–518)

The current position of AOA within the Department of Health and Human Services is not conductive to AOA's performing its role under the Act. The Commissioner should be elevated to the position of Assistant Secretary. In light of the demographic data presented earlier, it is appropriate that future political and policy decisions regarding the elderly population be made by a person at the highest level of the Federal Government. The current aging network does not have the capacity to meet existing needs among the elderly. With the older population growing, leadership is needed at the Federal, State, and local levels. (pp. 515; 518–519)

Regarding the capacity of AOA to improve the efficiency, coordination, and dissemination of data collection, additional burdens for data collection should not be placed upon local programs, AAAs, and State agencies. Reporting data costs money. Often, the local people who produce the data are overworked. Rather than requiring the production of additional data, a better approach would be to move carefully analyze and extract additional information from existing data.

Finally, the role of the Federal Council on Aging could be strengthened by providing it with the authority to hold hearings throughout the country on various issues that affect the elderly. Congress should also permit the Council to hold a White House

Conference on Aging every 10 years. If this were accomplished, then State directors would know when to expect these Conferences. (pp. 515-516; 519)

Mr. Edward Keenan, Director, Montgomery County Aging and Adult Services, Norristown, Pennsylvania. (pp. 520-523; prepared statement pp. 524-527)

Topic: The AAA Perspective.

Although coordination of activities at the Federal level is very important for AOA, it is not very important to the local agencies. The AAAs are most interested in defining exactly what activities need to be coordinated. What activities require the coordinated efforts of all the AAAs? Natural care giving communities, where people can obtain health and social services, exist within each AAA. It is among these communities that coordination of AAA activities should take place.

If AOA provides technical assistance, it must do so to facilitate coordination. AOA should look at the various ways coordination may occur and then share that information throughout the country. The OAA's original mandates for AAAs required the provision of comprehensive services can be provided if the requisite funding is available. The coordination of service providers, however, to develop a system of service is considerably more difficult. The system suffers from fragmentation rather than coordination. There is little information available about what others in the system are doing. (pp. 520-521; 524)

In discussing the coordination issue with small groups of health care providers, especially nursing home and hospital administrators and social workers, the systemic fragmentation became clear. The health care community itself tended to encourage people to enter nursing homes. The natural care giving communities of different AAAs, which provided services to similar people, needed to work together. This conclusion contradicted popular sentiment that AAAs can only coordinate the services that they provide. The entire health care system and the AAAs must work together.

Health care providers need to identify common goals and understand that all are working for the common needs of elderly persons. Older people will live more freely and thrive when the service systems are interdependent and view each other as interconnected parts of a larger service network. Today, only a few States have a single State agency with authority to give direction to various service systems. (pp. 521-522)

Within this network, the AAAs must originate and bring service providers together. In our community, four distinct groups have been meeting regularly for 7 years in what is called the long-term consortia. These groups include nursing homes and hospitals, health care agencies, personal care homes, and home-delivered meals. These groups are funded by our office. Currently, these four groups represent 200 agencies that have tended to agree on certain priorities to focus their efforts. They have been very active and cooperative with each other. The attitude has changed from one of confrontation among the different agencies to one of collaboration and communication. These groups have enlightened and educated themselves and have transformed the natural care giving communities into a unified service network. This consortia model is just one of many that AOA should consider to develop an informal method of coordination. (pp. 522; 526)

The more formalized method of coordination involves the case management function. This function needs to be addressed more fully in the OAA. Presently, it receives little mention in the Act. The State unit on giving and the State department of aging have made great progress in the past 12 months through its collaboration with AAAs. This is the critical role that the AAAs play for those elderly who are chronically ill.

More recently, the Department of Aging has instituted preadmission screening and other services statewide after successful experimentation in specific areas of the State over the last 6 or 7 years. The AAAs coordinate their efforts in servicing both the chronically ill and the acutely ill. As a result, the AAAs are now able to divert some people from nursing homes by sustaining them in their homes for a longer period.

This formal method of coordination, coupled with the long-term care consortia, represent the heart and soul of the OAA. The original objective of the Act was to help the elderly stay in their homes as long as possible. This goal can be achieved through either formal or informal coordination of agency activities. The OAA reauthorization must not only address the issue of adequate health care, but also the necessity of coordinated care to assure the proper placement for members of the elderly community. (pp. 522–523; 526–527)

Mr. O. Lewis Harris, Director, Forest Hills Community House, Forest Hills, New York. (pp. 528–530; prepared statement pp. 531–536)

Topic: Perspective of an Urban Service Provider

In New York City, as in most parts of the country, networks providing services to older adults are faced with the challenge of meeting the growing needs of the elderly population (60 years and older) as well as the special needs of the oldest elderly (75 years and older). Demographic studies predict a dramatic increase in this population over the next decade.

Minority elderly have also grown in number. They now represent a significant portion of the urban population. Approximately 3 out of every 10 older persons in New York City is a member of a minority group. Athough they tend to be among the younger elderly, the needs of minority elderly are often similar to those of the very old, indicating a lifetime of low income and poor health. (pp. 528; 532)

Urban service delivery systems are struggling to overcome problems with design and delivery of services to older adults. Minority access to available services is a critical issue in New York City. Most providers face stiff shortages and long waiting lists for services, especially in-home services. Preventive service dollars for adult day services, nutrition programs, and congregate services have eroded the economy. The lack of these services, or the inadequacy of those services that do exist, force many older people into the long-term care system prematurely.

To realize its basic mission as defined by its 10 objectives, the OAA should re-emphasize the importance of AOA, the State units, and the AAAs as focal points for developing and maintaining a system of services nationwide. To accomplish this objective on the national level will require the coordination of diverse Federal initiatives and a cooperative working relationship among all Federal agencies that impact on the quality of life of older Americans.

The Act must insure maximum flexibility at the local level if the local service providers are to meet the needs and conditions of individual communities. The OAA reauthorization must ensure that local needs and conditions play an essential role in the design of the service system. If so, service providers will enjoy the flexibility to respond quickly to individuals' needs in creative and innovative ways. (pp. 529; 533–534)

In order to meet the anticipated needs of a growing older population, the urban service providers must maximize the use of all available resources. This will require increased funding. For example, an increase is needed in Title IV funding for training, research, and discretionary projects programs.

Over the past few years, several million dollars have been awarded to State and local provider networks for applied research. These funds allow the networks to institute nationwide pilot projects and service models and to identify trends in the community. Cost-effective service systems are explored and developed. These discretionary grants stimulate innovative and creative apporaches to local service needs.

This increase in applied research should provide the nationwide network with knowledge of the types of projects funded, the populations served, successes and failures within the projects, and other important data. AOA should have the capability to identify and track national trends to establish the most efficient and most productive service models.

AOA should collect data nationwide regarding the quality of life of older Americans. It is equally important for AOA to have the capacity to process and disseminate this data. Without access to the knowledge and experience of the Federal findings, the aging networks at the State and local levels become locked into a continuous cycle of reinventing the wheel. (pp. 529; 534)

Current staff and funding constraints make it impossible for AOA to adequately share the information that comes from State and local networks. Consequently, providers at the local level are not informed of what AOA has learned from its discretionary programs. The same is true of client and service data collected at the State and local level which is submitted to AOA. Additional funds are needed to assure the dissemination of data that will improve the delivery of services to older Americans.

In addition, the OAA contains five or six mandates to be carried out by the Federal Council on Aging. These mandates include keeping the President informed, advocating for older adult issues, holding hearings, and disseminating information. At the local level, it is not apparent that these mandates are being accomplished. Many at the local level believe the Council has been ineffectual in its performance of its duties.

If direct service providers, especially those in the urban areas, are to properly address the needs of the increasing number of older Americans, the national network needs a Federal Council that is proactive. Presently, the Council receives $243,000. If the dissemination of information and the other responsibilities mandated for the Council can not be carried out, the Council's funding might be more productively spent if allocated to AOA. (pp. 529; 534)

The OAA has created a unique national network to improve the quality of life for older persons by providing them with essential services, As a society, we respond to crisis instead of effectively planning to avoid crises situations. The challenge has just begun as the population over 60 years of age, as well as those over 75 years, has increased dramatically. Sound planning today is critical if the aging network is to respond satisfactorily to the needs of this population.

The network's ability to respond, however, depends on the efficiency of the system and the adequacy of the funding. The Federal Government must ensure that the resources will be available in the future so that aging Americans will be able to obtain the services they need in their local communities. (pp. 529–530; 535–536)

Mr. Sidney Murphy, Director, Preston County Senior Citizens, Incorporated, Kingwood, West Virginia. (pp. 537–540; prepared statement pp. 541–544)

Topic: Perspective of the Rural Service Provider.

Every level of the aging network is understaffed and underfunded. The successful efforts of our organization would not necessarily be successful everywhere. The administration of AOA funding varies from one State to the next. The current financial climate in the country and the increasing need for services require the development of cost-effective methods of continuing quality service delivery to the elderly. As a rural service provider in West Virginia where funding is minimal, Preston County Senior Citizens has found that effective coordination and centralization of services increases service accessibility.

In recent years, as funding continued to decrease and the need for services increased, the local providers realized that the services provided had to be paid for with limited available resources. As a result, services were streamlined to assure their continued existence and to increase their availability. Despite this effort, the aging dollars are not able to meet the existing need or fill the gaps in the provision of needed services. (pp. 537–539)

Many counties across the Nation do not need multiple agencies providing the same service, such as transportation or in-home services. When dollars are distributed among too many services or service providers, the quality of the services dereases. Effort to coordinate services utilizing one agency provide a focal point for a comprehensive service delivery system. Our agency continues to work toward service specialization among providers.

For example, Title III(b) dollars and minimal donations once supported the elderly transportation program, which only served to transport senior citizens. Currently, the program operates vans that provide transportation for Valley Mental Health clients. The program is reimbursed $1.25 per client for this service. Then the vans distribute meals to the home-bound elderly and transport seniors to the nutrition site. The program receives 20 cents per mile for these services. After the meals are delivered and while the seniors are at the nutrition site, the vans transport in-home care providers to work. The seniors at the nutrition site are then returned home. The driver of the van spends the remainder of the day as an in-home service provider.

At the end of the day, the vans transport the other in-home service providers to their homes. Finally, this transit system picks up the Valley Mental Health clients transported in the morning and returns them home as well. Coordination of services can work. With the coordinated transit system, the work of five or six vehicles is accomplished by only one. The money saved in providing these services can be spend on improving the quality of services available. (p. 538)

Another example of effective coordination involves the senior center's provision of health services. Until this year, the senior center had a full-time nurse and a case manager. Presently, the senior center contracts with Prestion Memorial Hospital for nursing services, which saves $6,000 per year and increases the quality of services. The center and the hospital share a geriatric care manager, which saves $12,000 per year.

In addition, a community care program with an emphasis on geriatrics is in development with the hospital providing nursing and health services and the senior center providing the social services. Finally, home health services are now under the auspices of Preston Memorial Hospital, further reducing costs and increasing services.

This coordination of services, which has proven successful on the local level, must be accomplished at the Federal level. AOA should assess the social services presently provided under the Act and consider possibilities for coordinating these services. For example, OAA moneys fund chore services, housekeeping, legal services, and ombudsman services. The Department of Health and Human Services also funds chore services for the elderly and adult protective services. (pp. 539; 542)

Currently in Preston County, all chore services are being transferred from Health and Human Services to the senior center so that all persons over 60 years of age will receive services directly from one agency. The same could be done with adult protective services. Without this coordination of services in Preston County, local agencies would eventually cease to exist as funding continues to decrease. Coordinations does not require much money. It only requires time and cooperating among agencies, with a focus not on preserving an agency's territory but on meeting existing needs.

In West Virginia, a process of reorganization is underway through which service delivery for seniors statewide will become specialized. One of the barriers encountered in this process is that the majority of funding for aging services in West Virginia no longer come through AAAs. The nine AAAs provide only Title III(b) dollars, $54,000 of which comes to our agency. The annual funding for State aging services is over $1 million. The balance of this funding comes from other sources outside the AAAs. (pp. 539; 543–544)

The OAA should allow States the capability to change the organization or structure of AAAs. Presently, AAAs do not effect reforms where coordination of communications could be improved. Although there may once have been a need for nine AAAs in West Virginia, today each county has a senior provider who provides all the direct services for the elderly. All Title III(b) funding comes to the particular senior provider through the AAAs.

The OAA should also permit aging services to charge for services on a sliding fee scale. Some who receive services are able to pay for those services, but the Act only allows for donations. The Title III(c) nutrition bidding process should allow a waiver in rural areas where competition is nonexistent. In Preston County, the bid process is simply a waste of time and money. Finally, Title III(d) funds should be consolidated into Title III(b) because the funds pay for the same services but require separate tracking and reporting systems. (pp. 539–540; 543–544)

PARTICIPATION FROM THE AUDIENCE

Ms. Anna Kindermann, The Senate Special Committee on Aging: Whose role should it be to assure that the local service providers receive the needed information through the aging network? (p. 545)

Mr. HARRIS. A great deal of national data has come down to the local level. In trying to provide quality services with scarce public dollars, it is important to gain information on national trends and on successful programs operating across the country. This information needs to come to the local level from AOA. (p. 545)

Ms. CRECY. AOA is working with the Census Department in analyzing 1990 data. State agencies, AAAs, and other representatives are assisting AOA in determining the subject matter of the tabulation, the level of geographic detail, and the proper method for dissemination of the data. It is AOA's hope that this effort will provide State and area agencies with useful data. (p. 545)

Mr. Fred Luhman, AOA:

The question of reaching local service providers with this kind of information is complicated by a number of factors. One, there is no national list of all the people providing services to older persons on the local level. Second, the number of local agencies that need this information number over 10,000 and perhaps as many as 15,000.

The cost of replicating and distributing materials to each of these local agencies, as well as the cost of maintaining a reliable list of local providers, suggest it may not be practical nor cost-effective to undertake this task on the national level through AOA. A more practical alternative to AOA might be State and area agencies, which can better identify the local providers and assess the costs of dissemination of information. (pp. 545–546)

Mr. KEENAN. To re-emphasize this last point, AOA passes information to the States which then pass the information to the AAAs. The State agencies must assume the responsibility of providing local providers with important information. As I mentioned earlier, some of the local agencies have generated newsletters that gather information from various sources and then convey this information to those on their respective mailing lists. Those in government must work closely with the private sector to develop a mechanism to disseminate vital information. (p. 546)

Mr. Glen Dunbar, Pennsylvania Department of Aging: The provision of information to the local level is one of the most important roles for AOA and, currently, one of its greatest shortcomings.

AOA is definitely understaffed and it needs the resources to provide information to the persons who need it.

AOA is similar to a manufacturing plant or private sector business that lacks a sales force and continues to produce good products. AOA produces novel ideas and, through the discretionary research program, extensive research. It also develops good model programs, but it does not have the sales force to put their ideas and products in the hands of individuals who can make effective use of them. A sales force needs to be established if AOA is to disseminate information to the local level. (p. 546)

Mr. Larry Rickards, National Association of AAAs:

A number of suggestions have been made for increasing technical assistance, coordination of services, etc. Apart from decreasing funds, what other factors inhibit AOA's ability to fully disseminate information? (p. 547)

Ms. CRECY. AOA is doing the best job possible given the limited resources available. Interagency agreements have been very important to AOA as a means of providing technical assistance and coordination at the local levels. The agreements convey the message that AOA is concerned and is working with other agencies.

For example, through coordination of efforts with the Department of Transportation and the Department of Health and Human Services, AOA developed a best a practices manual on human services transportation and provided it to State and area agencies on aging. This type of document can then be reviewed at the State level to determine what efforts are successful accross the Nation and which would be successful in a particular State. AOA also funded workshops in Texas and Ohio which used the manual as a basis for discussing how other States' programs might work and how these programs can be effective on the local level. (p. 547)

Mr. RICKARDS. Many persons have stated that AOA have lost staff at the central office and in the regional offices. If AOA received an influx of funds, would staff levels be restored or have certain positions have permanently lost of shifted to other departments or agencies within HHS? If staff were to be hired with additional funds, would AOA be able to do this right away or would it have to go through bureaucratic channels? (p. 547)

Ms. CRECY. The Federal Government has a process for hiring staff. AOA would have to proceed through the Office of Personnel Management with an open announcement regarding available positions. AOA looks forward to having the opportunity to hire persons with practical experience in areas like nutrition or an ombudsman who has worked at the local or State level so that these individuals can impart that expertise to AOA. (pp. 547–548)

Ms. Nancy Danielson, National Farmers Union:

How good is the coordination between programs providing training and employment for older Americans within the different local agencies? (p. 548)

Mr. SANDERSON. If your preference is to Title V programs, the coordination of efforts has been successful. Our office meets periodically with all the Title V grantees to work on an equitable distribution Plan. The Job Training Partnership Act (JTPA) program in Arkansas is presently working well, though recent changes threaten its continued existence. (p. 548)

Mr. MURPHY. The Title V program in West Virginia has had no problems with training employees. These employees are then placed in different positions in the community. The different programs that have developed in recent years are in competition with each other. This appears to be the only problem with the programs in West Virginia. (p. 548)

Mr. KEENAN. In Montgomery County, a few staff members have remained in the JTPA and Title V programs for a long time. These programs work very closely with the private industry councils and the employment service. In addition, a number of the staff members have some unique experience that can be imparted to those they serve. Finally, efforts at coordination of services has progressed well in our country. (p. 548)

Mr. John Olinger, Subcommittee on Human Services, the House Select Committee on Aging:

Last month, the Subcommittee held a hearing on data and research dissemination under Title IV in which testimony was presented from the GAO. Clearly, people in the aging field are looking for better ways to obtain program information and to discover the results of research being conducted. The hearing also highlighted the recent AARP Public Policy Institute study on data collection and minority participation.

Although some have cautioned against increasing the burdensome reporting requirements, it is very apparent to those in Congress that, in trying to evaluate targeting and address other important issues, more reliable information is needed. How much time do State and area agencies spend in trying to meet the data reporting requirements that are curently in place? How can the reporting system be improved so that Congress receives the needed information to make proper recommendations for future changes? (pp. 548–549)

Mr. SANDERSON. The reporting burden is rather significant. The data that has to be collected from the Title III programs must be recorded at the point that services are delivered. As the buying power of Title II dollars have diminished some 30 percent over the last 10 years, site directors and those that work in the senior citizens centers face greater demands on their time. However, they still must collect a tremendous amount of information. Many of those who received services may visit the center five times every day, receiving a different service each time which must be recorded.

Arkansas is one of many small States trying to meet the burdensome reporting requirements. Simply accounting for the transportation service is a difficult task given the large number of one way trips that must be counted. Four or five years ago, some States tried to develop an automated information management system. In the last 13 years, however, no one has developed a system that is specifically designed to facilitate information dissemination across numerous States.

In developing this automated information system, it is important to consider that OAA dollars constitute a small percentage of the funding for the various local programs. These programs also report considerable funding from other sources. The proposed information system must include reporting data regarding all funding sources. TItle III dollars are no longer the only ones involved. (p. 549)

Mr. MURPHY. Of all the funding received by Preston County Senior Citizens, Inc., Title III dollars require the most paperwork to comply with the reporting requirements. The deadlines are tighter because the paperwork is most time consuming. The OAA needs to develop some flexibility in the reporting requirements.

For example, our transportation program, which uses Urban Mass Transit Administration (UMTA) 16(b)(2) vans, complies with the 16(b)(2) reporting requirements. Title III(b) funding provides gasoline for the vans. Consequently, the program must also comply with Title III(b) reporting requirements. Two separate reporting systems must be maintained, counting different units for the same particular trip. For UMTA 16(b)(2), each person that boards the van is considered a unit. Under Title III, the unit to be recorded is the particular one-way trip. The driver must keep two sets of reports which the program must in turn collect from each driver. Changes must be made in the Title III reporting procedure to remedy this tremendous waste of time and resources. (pp. 549–550)

Mr. KEENAN. OAA dollars in Pennsylvania represent about 30 percent of the State funding. The remaining 70 percent is State dollars. The OAA funding, however, is tightly regulated. With approximately 70 providers statewide, great effort is expended in gathering all the required reports from each program and collecting all the required data. The OAA reporting requirements should be relaxed because OAA money constitutes such a small percentage of the overall funding. (p. 550)

Mr. RICKARDS. What is the estimated cost of fulfilling the OAA data requirements? (p. 550)

Mr. KEENAN. With a small staff, the costs are very high. These costs are spread throughout the system. One of the sources of friction between our office and the local providers is tight time constraints within which the reporting must be accomplished. If the reporting requirements were relaxed, the relationship between State and local agencies would improve. (p. 550)

Ms. Anna Madison, Texas Southern University, Houston, Texas: How often does AOA evaluate the priorities of the coordinated discretionary funds program? (p. 550)

Ms. CRECY. Built into each of the discretionary grants is a process for monitoring and evaluating the programs. A recent effort is underway to bring certain types of grants together. In what are called cluster meetings or cluster reviews, several grants in a particular area such as health promotion are reviewed to discover what information is produced and how that information can be effectively used.

This review is done at various stages throughout the grant process. At the beginning, the emphasis is on what the grants are designed to achieve. At the end of the process, the focus of the review is on the actual results of the grant. The ultimate goal of these periodic reviews is to improve communication and to assemble an information package that will be useful to people throughout the aging field. (p. 550)

Ms. MADISON. A major concern for me and my colleagues who have reviewed programs in this grant process is the lack of an evaluation of certain types of programs that have existed for a number of years. Such programs have accumulated sufficient information to assess whether they are effective programs and whether the appropriate methods are employed to achieve the policy objectives of a particular program.

The OAA does not provide a mandate for AOA review of these long established programs. An additional mandate in the Act would be another responsibility to be funded by a limited budget. A major need exists, however, to review those programs that are continuously funded but ineffective. The aging network at the local level knows that these programs do not fulfill their respective mandates. The OAA should include a provision for periodic evaluation of these programs to determine what works and what does not. Through these evaluations, the entire service system could be improved. (p. 551)

Ms. Crecy. The OAA does have approximately $325,000 set aside for evaluation. Given this limited budget for evaluations of existing programs, the studies conducted are by necessity on a very small scale. Currently under consideration for 1991 is an idea to direct some of the Title IV discretionary money into assessments and evaluations of the Title III program rather than the grants under Title IV. This is a very important area which requires much greater attention. (p. 551)

Ms. Enid Kassner, AARP:

Without a reporting requirement, how can an agency document that it is meeting the goals of the OAA, particularly with regard to services to minorities, low-income persons, and other vulnerable elderly? (p. 551)

Mr. Sanderson. No one is recommending that the reporting requirements be abolished. Rather, they should be relaxed so that the burden on AAAs is not so great. Many people come in and out of the various local programs. A computerized system is necessary to accurately account for the services provided. Few service providers, especially in the rural areas, have computerized systems. More often a manual system is used in which cards must be counted and each factor on each card represents a piece of data that must be organized and calculated. (pp. 551–552)

With the rising demand for services, data regarding the services provided may not be necessary. Rather, a study of local demographics to determine those persons in need of services inform providers where increased efforts are needed. For example, census data reveals that Arkansas has the third highest poverty rate among elderly in the Nation. There is no need to count a great deal of data to know that the State aging network needs to serve this population.

This is not to say that data should not be reported. But local providers do not have the capacity to identify, record, and collect every piece of data that AOA or other agencies might deem important. State agencies face an easier task since they simply take the reports from the AAAs, add them together and send them to AOA. At the service level, however, information gathering uses much of an AAA's limited time and resources.

State agencies are trying to help the AAAs with State general revenues to implement a computerized information system. The

State legislatures should try to allocate more money for this purpose. Our agency has received far more money from the State legislature than from increases in AOA funding. (p. 552)

Mr. HARRIS. Little funding for delivery of services in New York State comes from AOA. Consequently, it is difficult to assess AOA's affect on the local provider. The bulk of funding for service delivery to older people comes from State tax dollars and city tax levy moneys. Each has its own reporting requirements, so that the reporting requirements imposed on local service providers is quite monumental.

The effort continues to persuade the city and State to consolidate their reporting requirements. Although it is unclear how much of the information reported goes to AOA, AOA should take the leadership in encouraging the State units and AAAs to consolidate and review their reporting requirements. Currently service providers suffer from duplicative reporting requirements. (p. 552)

Mr. Dan Quirk, National Association of State Units on Aging: This discussion regarding the current reporting system is not a new one. Local service providers, AAAs, and State units always mention that there is more reporting with the Title III moneys than almost any other service programs in the Nation today. In Washington, however, the common message is that the aging network does not know who is receiving services under the OAA. Perhaps the issue is not that too much data is collected, but rather that the data is disseminated incorrectly. How can this problem be resolved? (pp. 552–553)

Mr. HARRIS. Through contacts with the city department of the aging and the State office for the aging, it seems that the local agencies report the information to AAAs, the States, the Federal agencies, etc., but no information comes back to the service providers from these sources. (p. 553)

Mr. MURPHY. Our organization used to track only those persons 60 years and over. Today, we track a growing list of groups, including minorities, 75 years and older, etc. The assumption is that this data is required by someone, but it is unclear exactly where the collected information is going. This is not to say that local providers do not want to report, but the amount of information required per client is prohibitively expensive in terms of time and resources. If these reports are necessary, then funding and staff should be provided. (p. 553)

Mr. SANDERSON. Our organization has an extensive database. It is unclear precisely what information is needed other than what is currently reported. Our reporting system uses an intake form with over 30 pieces of information to be collected on every client. (p. 553)

Mr. HARRIS. Model programs and numerous services are being tested throughout the country with Federal dollars, but the only time that anyone hears about these new ideas is at a National Council on Aging conference. To assist local agencies in their effort to provide elderly services, information regarding the successes and failures of other programs in the country should be made available to the AAAs and local service providers. (p. 553)

Ms. CRECY. The best practices material is very useful. AOA certainly could provide more of that service for local agencies. In addition, the basic data information is collected in AOA, aggregated and then disseminated in an annual report that is sent to the local providers. The report includes how many people are receiving services and what kind of services are provided. (pp. 553–554)

Mr. LUHMAN. In some instances, Federal agencies other than AOA have their own reporting requirements. If the recommendation is that AOA should accommodate its reporting system to UMTA 16(b)(2) or to any of a multitude of other Federal agencies, then who coordinates the two reporting systems and determines what the reporting data will be? This poses a statutorily and administratively large task which AOA could not accomplish on its own.

In addition, more than one speaker has noted that a significant amount of the money going to AAAs, and then beyond them to local service providers, comes from State funds. If State reporting requirements are established for the use of those dollars, then AOA is not in a position to alter those State-imposed requirements nor to bring conformity among each of the various State requirements. AOA is only one player in resolving this problem and is therefore limited in what it can and cannot do within the Title III requirements for reporting. (p. 554)

Ms. Antoinette Samuel, Prince George's County Department of Aging:

If the reported data is aggregated and disseminated annually, what is the rationale for requiring data from the local level on a quarterly basis? Perhaps relaxing this requirement would alleviate some of the burden of the reporting requirements. (pp. 554–555)

Ms. LUHMAN. Reporting to AOA is annual, unless the States or local communities set other guidelines. (p. 555)

Mr. HARRIS. It is true that States have their own reporting requirements and that AOA cannot dictate to the States what the reporting requirements should be. A different perspective should be adopted, one that sees AOA as the center of a wheel. AOA represents the Federal view. The States must address the needs of AOA. Then AOA could suggest to the States that they incorporate Federal reporting requirements to their State form rather than duplicate them. This would provide a leadership role for the Federal Government.

Local service providers will certainly advocate for streamlined reporting procedures. The local agencies put pressure on the city which in turn pressure the State to change the current reporting requirements. But this process must start in Washington with AOA to which all other levels look to for leadership. (p. 555)

Mr. MURPHY. West Virginia imposes a requirement of monthly reporting. The reports from the local agencies are due by 4 p.m. on the fifth working day after the last day of the month. The State, however, provides only quarterly reports to the local agencies. (p. 555)

Mr. QUIRK. This raises an important issue regarding how to assess the national data provided by the OAA requirements. Currently, the OAA represents half of the budgets of State and area agencies. This shows some commitment from State and county governments in allocating funds for services to elderly persons.

In assessing the national data provided under the OAA, it is incorrect to assume that the data represents the full extent of services to older Americans. State and area agencies use the OAA to compliment State and country dollars that provide additional services. AOA has no information regarding who is being served through this other funding or the additional services provided. Although a massive reporting system is not necessary to assess this other funding, some sort of sampling would be useful to identify who is receiving services through the other 50 percent of the funds that flow through the aging network. This would help identify those who are still in need under the OAA as well. (p. 555)

Mr. MUSSELWHITE. In the 1990's, many new services may become available. State agencies, AAAs, and local service providers are presently working with many different programs. With multiple data requirements and an increasingly diversified service network, what role should the OAA and AOA play in working with these various programs and services? (pp. 555–556)

Mr. KEENAN. Our agency is more than simply an aging agency. It provides, for example, services to low-income adults. This additional service developed because many people under the age of 60 had many of the same needs that the elderly have. In Pennsylvania, this population was not receiving needed services. Other agencies responded to the needs of children or the elderly, but not to those of people in the middle. Our agency identified this gap and tried to fill it. Consequently, a very complex set of reporting requirements have developed.

The Department of Public Welfare in Pennsylvania has fewer reporting requirements requiring less staff time. There is also a longer grace period for submitting collected data to the Department. AOA's pressuring of the State units, which then translates into pressure on the local level, is the only sense of urgency felt by the local agenices in satisfying the reporting requirements. Other separate State programs have unique requirements which increase the difficulty of computerizing all the needed information. AOA should take the lead in alleviating this pressure on local agencies. (p. 556)

Mr. SANDERSON. Specifically, AOA could work with other Federal agencies to articulate common service definitions. Why should one Federal agency require a report for every round trip and another agency require a report for every one-way trip? If issues such as this could be resolved at the Federal level, perhaps it would become easier for local agencies to meet all the different requirements. (p. 556)

Mr. Al Steincerruci, GAO:

A recurring issue involves minority participation rates. Do those at the local level have a sense of whether minority participation is truly declining? If so, what could be the reasons for this decline? (pp. 556–557)

Mr. HARRIS. In New York City, there is an initiative to increase access for minority populations. Minority participation is not in decline. In fact, it is probably increasing because of the focus on outreach to minority populations.

One obvious problem is that if you are working with a minority population that is not English speaking, then the staff that provides services to this population should speak the population's langauge. Once this is accomplished, and other cultural differences are identified, then the services become much more accessible and more comfortable for the minority population. (p. 557)

Ms. KINDERMANN. What types of data are needed at the local level? What kind of information would the local service providers like to have from AOA and in what form would this information be most useful? (p. 557)

Mr. HARRIS. Those at the local level involved in service design are always identifying problem areas. The information on discretionary projects is critical. It is also important to understand which areas of the Nation face similar situations to the ones particular local providers are addressing. This allows a local provider to perhaps learn of effective solutions that have not yet been identified in his area.

Better planning and better services will be the result if local providers are given an accurate picture of the overall aging network. National information that is reported to AOA, such as best practices, minority populations, programs in cities that have a local old-old population etc., will give local providers additional tools with which to improve services. (p. 557)

Mr. MURPHY. The needs in urban areas are very different than the needs in rural areas. The annual report should distinguish between those services provided by rural agencies from those provided by urban agencies. Currently, rural providers read about a service provided elsewhere and wonder why that service would be needed in a rural area. (p. 557)

Ms. BRAUNSTEIN. In addition to the transportation example cited by Mr. Murphy, are there any other examples of Federal reporting requirements that are in conflict? Are there particular areas where different Federal agenices impose duplicative reporting requirements? (pp. 557–558)

Mr. SANDERSON. Arkansas allocates States revenues for the programs and tries to model the use of those funds after the Medicaid system. Where Medicaid is inadequate, such as with home-delivered meals which Medicaid will not pay for without a waiver, Arkansas designed a waiver to match the Title III home-delivered meal benefits. (p. 558)

Mr. Carl Fenstermeker, GAO:

To what extent do people at the local and State levels find the collected information useful? What types of information is not needed? (p. 558)

Mr. HARRIS. In New York City, an initiative is underway to streamline paperwork and reporting. A great deal of paperwork does not go back to the State. It is important for local providers to develop a working relationship with their counterparts at the city and State levels. Often, two different requests for information are actually the same request. One report perhaps could satisfy both requests. Every level needs some information for some reason. Government is additive, not incorporative. As in New York City, to meet the informational needs on the national level is a monumental task. (p. 558)

Mr. MURPHY. West Virginia uses a form that only requires prospective clients' birthdates, names, and addresses to assure that they are eligible to receive services. Below that, the form includes 52 optional questions regarding housing, physical limitations, income, etc. If the client chooses not to answer these questions, then the staff must complete the form requiring extensive guesswork. At that point, how useful could this information be to anyone? (pp. 558–559)

Mr. KEENAN. The Pennsylvania State unit has done well at sorting the collected information and disseminating it to those who will find it useful. Some information that may be relevant for a care manager would be critical to an AAA. At the State level, it has also tried to coordinate information that may be used again in the State-sponsored programs. The dilemma is that with each year, more information is required. In Pennsylvania, fortunately, the State unit and the AAAs work together to resolve problems with the reporting system. (p. 559)

Mr. DUNBAR. In Pennsylvania, there is also a clear trend toward computerized reporting systems. Although not every AAA has a computerized system, most do and in the very near future all will. Resistance to the use of technology will work to the disadvantage of the aging network. Perhaps AOA can promote the use of computerized data systems and develop a hardware contract that would be both workable and cost-efficient across the Nation. (p. 559)

Mr. MURPHY. Computerization has posed a difficult problem in West Virginia. The State computerized its reporting system 3 years ago with the understanding that the manual system could be abandoned after 1 year. Presently, both systems are used and the reports from each do not reflect the same data. At some point, technical assistance is definitely necessary from the state level to the local level. This technical assistance is currently nonexistent in West Virginia. (p. 559)

Mr. OLINGER. Many speakers have indicated support for upgrading the status of the Commissioner on Aging to the level of Assistant Secretary. In addition, some specifically recommended that the Commissioner have control of her own budget including salary, travel expenses, etc. First, what experiences suggest that her lack of control over the budget is a problem that impacts on your efforts? Second, what would be the beneficial effects of implementing these recommendations? (pp. 559–560)

Mr. SANDERSON. With regard to your first question, the regional office for Arkansas has occasionally failed to perform annual assessments of our agency or our program. Regular assessments help to keep local programs performing properly. With high turnover rates among staff, agencies and local programs do not benefit from waiting 5 years for outside assessments that identify problems which could have been solved by an earlier evaluation. AOA does not need an extensive monitoring and evaluation branch, but it is an appropriate role for AOA to assess AAA efforts. AOA has the travel money to effectively conduct these evaluations which could prove to be both constructive and preventive.

The elevation of the Commissioner is in large part a symbolic change. Having someone at the highest level of government can provide an invaluable perspective. Once the Commissioner is elevated from the bureaucratic level, she carries more credibility and influence. Consequently, the service programs tend to be viewed more positively. (p. 560)

Mr. KEENAN. In Pennsylvania, there was a movement toward establishing a separate cabinet level unit on aging. The people put tremendous pressure on the State legislators and the movement failed. The role of the Commissioner may change, but only as the people themselves want it to. It is not clear whether elevating the Commissioner will have much meaning for older Americans. Organized older adults, such as AARP, are not coming forward to exert the kind of pressure that was felt at the local level in Pennsylvania. (p. 560)

Ms. MADISON. The Commissioner presently participates in the policymaking meetings with the Secretary because the Secretary chooses to have her there. If the position were institutionalized by making it an Assistant Secretary post, would that really make any difference? (pp. 560-561)

Ms. CRECY. In 1987, the OAA was amended to require the Commissioner to report to the Secretary. This amendment was interpreted to mean that the Commissioner not only discuss policy matters with the Secretary but that she be a full member of the Secretary's senior staff. This is not a development that only came about with the arrival of Secretary Sullivan. (p. 561)

Mr. MUSSELWHITE. Many have mentioned assistance that State and local agencies would like to get from AOA for various activities. The discussion has considered technical assistance, data collection, dissemination of research and demonstration results, and salesmanship. Given the limited resources available, what would be the one or two types of assistance from AOA that would be more valuable to the State and local agencies? What are the most pressing needs that AOA should address? On the other hand, what would help AOA to remove barriers to providing this assistance? (p. 561)

Mr. DUNBAR. The most pressing question involves technical assistance. Our organization needs help in acquiring a Medicaid waiver. This requires working with HCFA and sorting through the Medicare regulations to obtain a Medicaid waiver to expand available services. This is a very complex effort with which AOA would probably be of little help. (p. 561)

Mr. SANDERSON. About 2 years ago, the Arkansas State unit began the process of acquiring a Medicaid waiver. Other States and Medicaid agencies around the country were approached. Access to AOA, which is expert in Medicaid waivers, would have been very beneficial in the course of negotiations with the local HCFA. AOA could have offered different perspectives on interpretations of the Medicare regulations and policy. (p. 561)

Ms. Joanne Keiser, State of Maryland:

It would be helpful to have more information on accessing AOA assistance with private sector initiatives and how that assistance would compliment the services provided and funded by the public sector. (p. 562)

Ms. SAMUEL. How can AOA, through technical assistance or specialized training, help those at the local level to become more effective transportation managers, particularly as the elderly population increases and those over 85 years of age need specialized transportation? (p. 562)

Mr. **Harris**. Training is another issue for which local agencies would look to AOA for assistance. On the local level, training dollars have become very scarce. Perhaps AOA has the same problem. As the local agencies identify the new dimensions of a changing older population, staff must be trained and prepared to meet this challenge. AOA must assist local agencies in this effort. (p. 562)

Mr. **Murphy**. Given the limited funds available, what other resources are available that can be utilized in conjunction with aging programs? What other Federal programs have aging dollars available? What grants are available? (p. 562)

Ms. **Crecy**. AOA would like to provide the local agencies with these funding alternatives. AOA faces a monumental task in trying to meet the needs of the State, area, and service provider level. AOA, however, needs to be more efficient in collecting and disseminating information. Interagency and intraagency agreements are ways that AOA is trying to accomplish many of the tasks requested by those at the State and local levels. (p. 562)

The Commissioner has hosted several roundtable discussions this year. More are scheduled for next year. For instance, one discussion focused on cost sharing, another on minorities, and a third on elder care. These discussions have proven to be invaluable ways of acquiring information from the various levels because all levels, including national organizations, are represented.

This format will continue to be used to generate the feedback necessary for AOA to be responsive to local needs. Communication, however, is a two-way street. State and local agencies should make use of the 10 regional offices on aging nationwide to voice concerns and suggest ideas. In addition, the Commissioner's office is always available to receive suggestions for improving the aging system. (p. 563)

Mr. **Harris**. No one has discussed the Federal Council on Aging nor a White House Conference on Aging. It appears that the OAA's five mandates are not being fulfilled. (p. 563)

Mr. Tetzloff, Deputy Director of Federal Council on Aging:

We are always working to make the Council more effective. The Council members meet four times a year on various issues. The issues that are discussed are brought to the table by Council members who feel the issues are particularly important.

The resources for the Council are limited. Most of available funds must go to travel expenses and staff functions. When 15 people come together four times a year, these resources disappear quickly. Consequently, the Council cannot be a very visible organization since most of its funds are allocated to internal operations.

The next Council meeting will focus on mental health and the elderly. Hopefully, a report will follow that will detail the issues discussed and articulate the current status of national mental health issues. There is also an annual report that is widely disseminated. One effort of the Council is to expand the mailing list for the annual report because it gives a summary of the various issues that the Council addresses throughout the year. (p. 563)

Mr. **Harris**. The Act requires the Council to review and evaluate Federal policies, and to serve as a spokesperson for older Americans in making recommendations to the President, the Secretary, and the Commissioner. These are very vital responsibilities. (pp. 563-564)

Mr. TETZLOFF. Recommendations consistent with those responsibilities are contained in the annual report. That report is then given to the President, the Commissioner, and the Congress. (p. 564)

Mr. OLINGER. Everyone is very aware of the shortage of resources at each level. One common complaint heard on the House side of the Select Committee on Aging is that Congress is not aware that there is a priority need for increased resources. Congressmen are not hearing from their constituents that increased funding for the OAA is needed. Many organizations regularly testify on this point, but millions of older Americans fail to exercise their power to write in and demand another $1 billion for the OAA. To what extent could people begin to build public support that would create pressure on Congress to increase the funding base? (p. 564)

[The limitations precluded the workshop participants from responding to this question. Senator Pryor concluded the workshop discussion.] (pp. 564-566; prepared statement pp. 493-500)

Senator PRYOR. This is the fourth in a series of informal workshops sponsored by the Special Committee on Aging this year. I am pleased to report that we have been very successful in eliciting valuable input through these workshops on the OAA as well as many other issues that affect our Nation's elderly population. (pp. 565; 493)

All of us gathered here today comprise the infrastructure of the aging community in our society. This infrastructure is critical to the delivery of services, the dissemination of ideas, and the provision of a backup system for those in the State and local communities. It is very important that we develop a better system of communication. This is one of the central advantages of forums such as this in which we can establish channels of communication and exchange ideas. Ultimately, we can better serve those who depend on us. (pp. 566; 500)

LEGISLATIVE RECOMMENDATIONS

1. The OAA reauthorization must not only address the issue of adequate health care, but also the necessity of coordinated care to assure the proper placement for members of the elderly community and to avoid unnecessary commitments to nursing homes. (p. 96)
2. AOA should have technical experts and specialists to assist the State and area agencies. AOA should not become an overpowering bureaucracy that simply generates paperwork. (p. 95)
3. The OAA should include language that gives the Commissioner on Aging complete authority over her salary and expense budget to adequately administer AOA. (p. 95)
4. The current position of AOA within the Department of Health and Human Services is not conducive to AOA's performing its role under the Act. The Commissioner should be elevated to the position of Assistant Secretary. With the older

population growing, leadership is needed at the Federal, State, and local level. (p. 95-96)

5. The role of the Federal Council on Aging should be strengthened by providing it with the authority to hold hearings throughout the country on various issues that affect the elderly. (p. 95)

6. Congress should permit the Federal Council on Aging to hold a White House Conference on Aging every 10 years. If this were accomplished, the State directors would know when to expect these conferences. (p. 95)

7. Additional information requirements cannot be placed upon local programs, AAAs, and State agencies. This would severely limit the capacity of AOA to improve the efficiency, coordination, and dissemination of data collection. (p. 95)

8. AOA should consider various models to develop an informal method of coordination among local service providers. One such model is the consortia model used effectively in New York City. A more formalized method of coordination involves the case management function. This function needs to be addressed more fully in the OAA. Presently, it receives little mention in the Act. (p. 96)

9. To realize its basic mission as defined by its 10 objectives, the OAA should re-emphasize the importance of AOA, the State units, and the AAAs as focal points for developing and maintaining a system of services nationwide. To accomplish this objective on the national level will require the coordination of diverse Federal initiatives and a cooperative working relationship among all Federal agencies that impact on the quality of life or older Americans. (p. 96-97)

10. The coordination of services, which has proven successful on the local level, must be accomplished at the Federal level. AOA should assess the social services presently provided under the Act and consider possibilities for coordinating these services. (p. 99)

11. AOA should have the capability to identify and track national trends to establish the most efficient and most productive service models. (p. 97)

12. AOA should collect data nationwide regarding the quality of life of older Americans. It is generally important for AOA to have the capacity to process and disseminate this data. (p. 97)

13. Additional funding is needed to assure the effective dissemination of data to improve the delivery of services to older Americans. (p. 97)

14. The OAA contains five or six mandates to be carried out by the Federal Council on Aging. If the dissemination of information and the other responsibilities mandated for the Council on Aging cannot be carried out, the Council's funding might be more productively allocated to AOA. (p. 97)

15. The OAA should allow States the capability to change the organization or structure of AAAs. Presently, AAAs do not effect reforms where coordination of communications could be improved. (pp. 97-100)

16. The OAA should permit aging services to charge for services on a sliding fee scale. Some who receive services are able to pay for those services, but the present Act only allows for donations. (p. 100)

17. The Title III(c) nutrition bidding process should allow a waiver in rural areas where competition is nonexistent. (p. 100)

18. Title III(d) funds should be consolidated into Title III(b) because the funds pay for the same services but require separate tracking and reporting systems. (p. 100)

19. To provide quality services with scarce public dollars, AOA must provide the local agencies with information on national trends and on successful programs operating across the country. (p. 100)

20. In developing an automated information system to facilitate collection and dissemination of vital information, it is important to include data for all local agency funding sources. Title III dollars are no longer the only ones involved. (p. 102)

21. A pressing need exists to review those programs that are continuously funded but ineffective. The OAA should include a provision for periodic evaluation of these programs to determine what works and what does not. Through these evaluations, the entire service system could be improved. (p. 103)

22. AOA should take the leadership in encouraging the State units and AAAs to consolidate and review their reporting requirements. Currently, service providers suffer from duplicative reporting requirements. (p. 104)

23. A different perspective should be adopted acknowledging AOA as the Federal view. The States must address the needs of AOA. Then AOA could suggest to the States that they incorporate Federal reporting requirements to their State form rather than duplicate them. This would improve a leadership role for the Federal Government. (p. 106)

24. Although a massive reporting system is not necessary to assess the impact of the State and county dollars that reaches the local service providers, some sort of sampling would be useful to identify who is receiving services through this funding, which constitutes 50 percent of the funds that flow through the aging network. This would help identify those who are still in need under the OAA as well. (p. 106)

25. The OAA reauthorization must ensure that local needs and conditions play an essential role in the design of the service system. The Act must insure maximum flexibility at the local level if the local service providers are to meet the needs and conditions of individual communities. (p. 96)

26. The AOA annual report should distinguish between those services provided by rural agencies from those provided by urban agencies. The needs is urban areas are very different than the needs in rural areas. (p. 108)

27. AOA should conduct annual evaluations of local programs through the regional offices help to keep the local programs performing properly. AOA does not need an extensive monitoring and evaluation branch, but it is an appropriate role for AOA to assess AAA efforts. AOA has the travel money to

effectively conduct these evaluations which could prove to be both constructive and preventive. (p. 109)

28. AOA should assist local agencies in maintaining a trained staff to meet the changing needs of a growing elderly population. (p. 110)

REAUTHORIZATION OF THE OLDER AMERICANS ACT

(Workshop No. 1)

WEDNESDAY, JANUARY 31, 1990

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The workshop was held in the Dirksen Senate Office Building, Senator David Pryor presiding.

Staff present: Portia Porter Mittelman, staff director; Christopher Jennings, deputy staff director; William Benson, chief of health and housing policy; John Monahan, professional staff; Anna Kindermann, professional staff; and Heather Dreyer, professional staff.

OPENING REMARKS BY SENATOR DAVID PRYOR, CHAIRMAN, SPECIAL COMMITTEE ON AGING

Senator PRYOR. Ladies and gentlemen, good morning.

We welcome you to this very, very informal workshop and informality, I hope, will prevail. It is the first Older Americans Act Workshop sponsored by the Senate Special Committee on Aging. It is in collaboration with the General Accounting Office. We very much appreciate their assistance.

It is my hope that this particular forum will examine the services authorized under the Older Americans Act and will suggest possible legislative options for the 1991 reauthorization. Again, I wish to stress that this is not a hearing. The Older Americans Act was signed into law during my first term many years ago in the House of Representatives. That was about 25 years ago, and it's safe to say that this Act has been a tremendous success.

Today there is a tremendous aging network throughout America: State units on aging in each of the 50 States, 670 area agencies on aging, and 25,000 service providers working together to offer a very wide range of social services and assistance to the elderly population. Although virtually static funding over the past 10 years has strained the aging network, it remains a viable and needed force in the lives of older Americans.

At the outset of this hearing, I would like to say that I am sorely disappointed with President Bush's budget proposals for the Older Americans Act. Those cuts include some $14 million from Title V employment programs as well as freezing all other Older Americans Act programs at fiscal 1990 post-sequestration levels.

The Title V cuts will be in effect the second cut for the program this year.

While the minimum wage increase provided much needed relief to many hard-working, low-income Americans, it may actually decrease the number of older Americans who could be served under this very successful program. Because of the vast majority of Title V funding going directly to older workers' salaries, President Bush's proposal, I think, will be picking the pockets of older Americans who do want and so desperately need work.

I think there's a remarkable feature of the Older Americans Act and that is the diversity of services that are provided to senior citizens. Unlike many complex Federal programs, this Act places trust and creativity right there on the local level, the State and local agencies, to address the diverse needs of our respective communities.

However, I believe that one thing ties these many diverse services together. The Older Americans Act is a hand that helps elderly persons maintain independence and dignity. This helping hand can be seen in many ways in our communities and in our society: A helping hand that delivers hot meals to a senior citizen; a helping hand to defend and assert the legal rights of an elderly woman who is striving to keep her apartment; a helping hand to guide an elderly man through the bureaucratic maze of Federal benefit programs; a helping hand of an ombudsman to advocate on behalf of the nursing home residents whose rights and dignity may have been violated; a helping hand to assure that minority elderly persons are treated with the fairness and respect that is their birthright; a helping hand extended to an elderly father and his daughter who need information about human services and those programs available in their community; a helping hand to obtain meaningful employment for an older man who needs to supplement his income.

This is just a sampling of the diverse and creative services offered by the Older Americans Act. These examples also illustrate what should be a guiding principle of the Older Americans Act and, that is, helping senior citizens maintain and restore their independence and their dignity.

As we look toward the 1991 reauthorization of the Older Americans Act, I hope we can improve upon the statute's ability to assist older Americans in achieving independence and dignity. Perhaps more fundamentally though, I hope we can ask whether the Act works as well as it could and whether it continues to be appropriate for the needs of the older Americans or what changes we might need to make.

Today's workshop is a first step toward such an examination of this Act. It will broadly consider the Older Americans Act services from three perspectives: target populations, services, and organizational structure. Each of our speakers this morning will present one of these points of view. Afterwards, the speakers will have an opportunity to comment upon each other's presentation before discussion is open to the floor. There may be even some disagreement. If there is disagreement, this is a good forum in which to express it.

I'm very pleased today that our distinguished speakers will be sharing their views with us this morning. For many years, Robert Binstock, Robert Hudson, and Percil Stanford, have published thoughtful analyses of this and other Government programs.

On behalf of the Special Committee on Aging, I want to thank our panel today. Just as important though are you in the audience. Many of you have worked for years in delivering Older Americans Act services. For your dedication, for your efforts, we salute you. In addition, I urge you to actively take part in today's discussion. Without the participation of those of you who are in the trenches and who are on the front line out in this crusade, we cannot gain the benefits of your special insights.

Again, thank you for attending this workshop. We look forward to hearing your viewpoints. At this point, I'm going to turn our proceeding over to our moderator, Jim Solomon of the General Accounting Office. Jim Solomon has worked with us on many projects over the past several years, both in the aging arena and elsewhere. His dedication, hard work, and thoughtful analysis have been exemplary. In short, Jim is a true public servant.

Let us also thank Sushil Sharma who works with Jim Solomon. Sushil is on my extreme right. Sushil has worked hard on these workshops. He has contributed long hours, his able intellect and his commitment in several prescription drug studies conducted on my behalf by the General Accounting Office. Like Jim, Sushil embodies the true spirit of public service. We want to thank both of these individuals very, very much.

Let me once again state that informality, I hope, will prevail this morning. I am very, very apologetic that I will not be able to be here for the entire proceeding. I will be coming and going, At 10, I have another meeting relative to long-term health care with many participants in the business community. At 10:30, we have the confirmation of one gentleman who is a nominee for the Postal Rate Commission and I will have to chair that, but I will be in and out this morning and will be spending as much time as possible in our workshop.

Jim, I'm going to turn it over to you.

STATEMENT OF JAMES SOLOMON, SENIOR ASSISTANT DIRECTOR, PROGRAM EVALUATION AND METHODOLOGY DIVISION, U.S. GENERAL ACCOUNTING OFFICE

Mr. SOLOMON. Thank you, Senator. We're certainly grateful for the amount of time that you can spend with us this morning.

My name is Jim Solomon. I'm Senior Assistant Director in the Program Evaluation and Methodology Division of the U.S. General Accounting Office. I just want to reiterate the point that the Senator made about the importance of these workshops and the importance of everyone in the audience participating as well.

It's certainly my opinion that the reauthorization of the Act is at a crucial and important time in its history and I say this for several reasons. First, the number of elderly is increasing substantially—has increased over the past—and particularly the number of old-old and the number of frail-old is rising quickly. This is a population that we desperately need to serve.

Second is that while the number of service providers is also increasing, I'm not quite sure that it's increasing at the rate necessary to meet all the needs. So I think we have to look at these two rates of increase. We have to consider how they're going to mesh together and how the Act can best meet these needs.

We're at a critical crossroads for the Older Americans Act. We have to carefully consider issues related to reauthorization in order to be able to continue to offer the helping hands that Senator Pryor talked about.

Let me get a couple of administrative matters out of the way first before I turn the discussion over to our panelists. I want to do three things before I turn it over. First is to reiterate the objectives of this workshop and those that follow. Second is very briefly in a very sketchy fashion lay out the titles of the Older Americans Act, probably boring for most of you in the room but let me go through the exercise anyway, and third is to explain once again the format of this workshop and how we intend to go about it. Again, then I'll turn it over to the speakers.

First, the objectives of the workshop series: The objectives are to raise important questions and to propose and assess options for responding to key issues that may merit particularly close attention as part of the reauthorization process. Moreover, as Senator Pryor has stated, the workshops will examine whether the Act remains appropriate for the needs of the elderly in the 1990's. Neither we the panel nor the committee itself can achieve these objectives alone.

I can't stress too strongly that it is our hope that each and every one of you in the room today will consider yourselves active participants in the process in helping achieving these objectives here at this workshop, at following workshops, and in the time in between.

As for the basics of the Older Americans Act, we have a whole bunch of charts behind us.[1] The one you can't see, the one down on the floor, is the one that talks about the different titles. Well, let me just go through them real quickly and some of the speakers will be addressing particular titles.

The first title, Title I, sets out broad social policy objectives oriented toward improving the lives of all older Americans. Dr. Hudson will be addressing this more in his presentation this morning.

Title II establishes the Administration on Aging to administer most Older Americans Act programs and to act as chief Federal agency advocate for older persons. It also establishes the Federal Counsel on Aging to advise the President and Congress regarding the needs of older people.

Title III establishes the authority of a network of State and area agencies on aging and requires the development of a comprehensive and coordinated service system for older persons. These are the helping hands that the Senator talked about earlier.

Title IV authorizes the Commissioner, AOA, to award funds for a broad array of training, research, and demonstration programs in the field of aging.

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[1] See appendix, p. 181.

Title V through the Community Service Employment Program authorizes funds to subsidize part-time community service jobs for unemployed, low-income persons, 55 years of age or older.

Title VI authorizes funds for grants to Indian tribes and native Americans for supportive and nutritional services.

Now let's revisit briefly the structure of this workshop. The procedure we'll follow here today is that each panelist will address one of the basic tenets of the conceptual framework we laid out in our letter of invitation. Again, that's target populations, services, and organizations.

Also, as you may notice on one of the boards behind us we have four unifying themes for this workshop and the ones that follow. Let me just address those real briefly.[2]

They are advocacy, that is, whether the agencies and individuals mandated to serve as advocates are effectively providing such service. Second is efficiency and effectiveness, that is, measuring whether services are being provided in an efficient, appropriate, and cost-effective manner.

Third is gap-filling, that is, providing information or services that are not being offered by other programs or institutions. Fourth is equity, that is, serving the persons who have the greatest need.

Now, let me go back to the structure after that. Our intent again is that each panelist will make a presentation. After the presentations of the panelists, each panelist will have a chance to respond to each other's paper and then we'll turn the discussion over to the floor. Again, the key term in that sentence was discussion. We really and truly need the participation of everyone in the room to make this workshop a success.

Our first speaker is Dr. E. Percil Stanford. He will focus on target populations. Let me just give you a little bit more of Dr. Stanford's background. He's Professor Director of the University Center on Aging, San Diego State University. He's also the Director of the National Institutes on Minority Aging. Director of National Resource Center for Special Aging Populations, and co-Director of the Geriatric Education Center. Dr. Stanford is the former president of the Western Gerontological Society, American Society on Aging, and the California Council on Gerontology and Geriatrics.

Dr. Stanford served as the specialist on aging at the Administration on Aging, regional operations representative for Social Rehabilitation Services, and he's also served as a congressional fellow. Dr. Stanford has received numerous awards, among them the annual award from the Western Gerontological Society for outstanding contributions to and leadership in the field of aging.

Dr. Stanford received his B.A. in sociology from Morgan State University and his M.S. and Ph.D. in sociology with an area of emphasis in gerontology from Iowa State University.

Percil, welcome and tell us more about target populations.

Senator PRYOR. Jim, before Percil begins, could we first make definite that all of the written statements will be printed in the record as if read. Could we establish maybe a ground rule on time? Would that be beneficial, so we can have a full participation?

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[2] See appendix, p. 184.

Mr. SOLOMON. Right.

Senator PRYOR. What is the panel's desire on how much time each would take?

Dr. STANFORD. Ten to 15 minutes.

Senator PRYOR. Ten to 15, fine, thank you.

STATEMENT OF DR. PERCIL STANFORD, PROFESSOR, CENTER OF AGING, UNIVERSITY OF CALIFORNIA AT SAN DIEGO

Dr. STANFORD. Or shorter. Thank you very much.

Senator Pryor, Mr. Solomon, Dr. Sharma, and the distinguished audience and guests. It's a pleasure to have the opportunity to participate in this workshop, I will focus, very briefly, on target populations and the reauthorization of the Older Americans Act.

First, the Older Americans Act of 1965 remains the most significant piece of social legislation of the 20th century. As stated in the preamble to the Act, it was established to provide assistance in the development of new or improved programs to help older persons through grants to States for community planning and services and for training through research, development, or training project grants.

This was to be done through the Department of Health, Education, and Welfare with the establishment of the Administration on Aging as the operating agency. The stage was thus set for addressing one of the most pressing and significant social change issues of the century and the emphasis should be on social change issues.

The Older Americans Act was perhaps at least 20 years behind time at its initial stage of implementation. Therefore, it has been a matter of trying to catch up with the rapid changes of the demographic profile of our society. The Act was originally to address the needs of all older Americans and to provide support to those assuming responsibility for the welfare of older Americans.

Title I of the Act, which is the declaration of objectives and definitions, spells out the intent of the Act. It states in part that in keeping with the traditional American concept of the inherent dignity of the individual in our Democratic society, older people are entitled to and it is the responsibility of the Government of the United States and their political subdivisions and of Indian tribes to assist older people in securing an opportunity to a full and free enjoyment of the objectives presented in the Act.

This has not been fully applicable to all people. We must be reminded that our basic laws and social structures do not allow for full participation by many of the now old minority individuals in our society. In further examining and evaluating the objectives spelled out in the declarations of the Act, it is clear that further consideration must be given to the language and perhaps the implications of the objectives for ethnic minority persons.

One of the first considerations in the reauthorization of the Act for 1991 should be to closely examine how the broad objectives of the Act provide for the inclusion of race, color, culture, and ethnicity. It's not enough to assume that those individuals, groups, institutions, and governments responsible for following the intent of the

Act will automatically include the additional dimensions mentioned above.

For example, objective No. 7 of the Act, mentions culture, but not from the perspective of the individual's unique characteristics or station in life. Culture in the context of the Act appears to be mentioned more from the standpoint of providing an opportunity for the individual to take advantage of those things related to the humanities and arts.

Since the Older Americans Act is a pivotal piece of legislation which provides leadership in determining the way in which a significant portion of our population for the 21st century will be treated, it is reasonable to set the stage for addressing the issue of whether populations "melt". The melting pot concept implies that as people age, they are homogenous and that we have a society of assimilated older persons.

There is mounting evidence that we are not moving toward a more assimilated society, but one which is less willing to become assimilated and amalgamated. In serving older people, there is now the acknowledgment that diversity is significant. For example, ethnic preference is allowed in nutrition programs and in senior center activities.

Mounting evidence also suggests that there is more support for the co-existence of cultural, ethnic, and racial groups with each supporting the other when appropriate and respecting the values and norms of others.

Several scholars have talked about diversity and the positive as well as the negative aspects of diverse cultural groups being recognized for their worth in a complex society. It would be well for the Older Americans Act to explicitly acknowledge that diversity has positive qualities. In order to understand and further operationalize diversity, it is suggested that the emerging concept of what I'm calling diverse life patterns be included in the language of the Act.

Diverse life patterns recognize the difference of older individuals and their collective life experiences. It does not assume or impose the need for comparisons across cultural, racial, and ethnic groups.

Policymakers, planners, educators, researchers, and others are then free to look at the specific needs of targeted populations and develop programs and allocate resources based on the specific circumstances of those groups. This in essence reduces many of the problems of trying to generalize services targeting populations which have very little in common. Targeting diverse age populations is the key to ensuring that older people in greatest social and economic need receive needed attention.

Targeting applies not only to race and language differences but also to the higher proportion of poverty among certain minority elderly groups. Recent efforts on the part of the Administration on Aging to better understand how targeting can benefit all persons and specifically those in greatest social and economic need is showing that targeting is one way of ensuring that services are more equitably distributed and I want to put the emphasis on more.

The National Resource Center on Minority Aging Populations conducted a study in 1989 which indicates that there is a willingness on the part of the aging network to develop guidelines for targeting formulas which ensure reasonably equitable distribution of services and resources. The formulas now include everything from simple one or two sentence statements to very complex statistically laden statements.

This induces confusion and sometimes a sense of inequity across States with regard to the national distribution of services. In simple terms, the authorizing legislation should be very clear by providing specific guidelines for standardizing funding formulas. To stem the tide of the burgeoning number of older persons who fall into the have and have-not categories, it is important to become much more clear and directive with regard to targeting services.

Specific guidelines dealing with how to successfully target populations should go along with the mandate to target services to minority older persons and those with greatest social and economic need. This would be a major service to aging program administrators throughout the aging network.

To bring about positive changes in the aging network and to adequately provide services to targeted populations, it is imperative that greater emphasis be put on education, training, and research. Education and training are the pivotal points around which change must occur. The past 10 years have witnessed a ravaging drought in support for educational and training programs in gerontology.

The major infusion of support has been at the doctoral and postdoctoral levels. The deficiency at the undergraduate level and predoctoral level has been most damaging. If we are to have well-educated and trained personnel to serve the diverse aged population, major responsibility for that cadre of individuals must come from the public sector.

It is ironic that the fastest growing segment of the older population is within the ranks of minority older persons while fewer and fewer ethnic minority individuals have the opportunity to receive training to serve older persons from similar backgrounds. We constantly bemoan the fact that we do not have qualified bilingual and bicultural administrators and service providers. If we do not support training and educational opportunities for these individuals, it will be virtually impossible to have sufficient numbers to begin to meet the growing need.

As far as research is concerned, there is a commensurate need for more basic and longitudinal studies to understand the changes occurring within the targeted populations. There are many key issues which have an impact on the quality of services and the quality of life of targeted populations. I'm going to mention a few of those at this point.

Home care—more rather than fewer older people are remaining at home and are returning home earlier after major illnesses. Minority older persons have historically been cared for to a greater extent in the home environment. This circumstance calls for greater support for the homebound. Thought must be given to how to increase ways in which assistance can be given with activities for daily living.

For example, more resources can be made available for assistance with housecleaning, shopping, personal care, et cetera. Transportation is another important area in need of attention. Transportation has plagued many targeted groups for some time. Assistance continues to be needed for reaching medical services. Consideration must be given to devising ways of funding transportation costs. Even with Medicaid, there are gaps in transportation coverage.

Employment—emphasis on employment for the elderly is beginning to shift toward the actual inclusion or the reentry of older persons into the labor market. Of major concern is the fact that many older minorities in targeted populations have not had good work histories and therefore would not likely be among those who would be employed based on previous work experience whether on a full-time or part-time basis.

Further, recent emphasis on volunteerism for older people is not as widely received by elders themselves because of an increasing need for supplemental income. Many older people in the targeted populations cannot afford to volunteer, nor do they come from backgrounds where volunteering to become involved in formal programs is the norm.

Retirement—the language of the Act uses the concept of retirement rather freely. Retirement, for the mainstream older person has a very specific meaning which is generally understood by most. A high percentage of older minority and culturally diverse individuals do not have the benefit of experiencing retirement in the traditional American sense. If we continue to base activities, programs, and benefits on retirement, segments of many diverse groups will be completely ignored.

Since retirement is based on the presumption that one has moved away from gainful employment in a formal or informal manner, many older persons do not fit the mold. The language in the Act should begin to refer to quality of life after work. The inference is that there are programs, benefits, and opportunities that are available after individuals reach a point where they no longer need to work on a full-time basis.

Retirement is becoming a nonconcept in that even those with formal careers are not following the traditional path of work and then retirement.

Health care—assistance for health care coverage remains inadequate. There's no need to elaborate here because there's a lot to be said. In essence, the above issues represent only a few examples of issues that directly shape the direction and fate of those included in the targeted populations. The Older Americans Act as amended in 1987 has many positive aspects which may be laying the groundwork for changing, enhancing, and providing more attention to targeted populations.

The reauthorization in 1991 provides a golden opportunity to put forth legislation that will serve as the framework for moving through the 1990's and into the 21st century.

In conclusion, further efforts should be made to reach and serve all targeted populations by understanding and developing programs based on diverse life patterns and not the melting pot or assimilation ideas.

Title I of the Act should include language which clearly states that preference will be given to older people with the greatest social and economic need.

Thank you very much.

[The prepared statement of Mr. Stanford follows:]

Reauthorization of Older Americans Act of 1965

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University Center on Aging
College of Health and Human Services
San Diego State University
January 1990

TARGET POPULATIONS: OLDER AMERICANS ACT REAUTHORIZATION 1991

The Older Americans Act of 1965 remains the most significant piece of legislation of the 20th Century. As stated in the preamble to the Act, it was established to provide assistance in the development of new or improved programs to help older persons through grants to the states for community planning and services and for training through research, development, or training project grants, and to establish within the Department of Health education and welfare an operating agency to be designated as the "Administration on Aging". The stage is thus set for addressing one of the nations most pressing and significant social change issues. The Older Americans Act was perhaps at least 20 years behind time at its initial stage of implementation; therefore, it has been a matter of continuing to try to catch up with the rapid changes in the demographic profile of our society.

The Act was originally designed to address the needs of all older Americans and provide support to those assuming responsibility for the welfare of older Americans. Title I of the Act, "Declaration of Objects and Definitions," spells out the intent of the Act. It states in part that in keeping with the traditional American concept of the inherent dignity of the individual in our democratic society, older people are entitled to, and it is a responsibility of the governments of the United States and their political subdivisions and of Indian tribes to assist older people in securing an equal opportunity to the full and free enjoyment of the objectives presented in the Act. We must be reminded that our basic laws and social structures did not allow for full participation by many of the now old, minority individuals. In further examining and evaluating the objectives spelled out in the declaration for the Older Americans Act, it is clear that further consideration must be given to the language and perhaps the implications of the objectives.

One of the first considerations in the reauthorization of the Older Americans Act for 1991 should be to closely examine how the broad objectives of the Act provide for the inclusion of race, gender, culture and ethnicity. It is not enough to assume that those individuals, groups, institutions and governments responsible for following the intent of the Act will automatically include the additional dimensions mentioned above. Objective No. 7 mentions culture, but not from the perspective of the individuals unique characteristics or station in life. Culture appears to be mentioned more from the standpoint of providing an opportunity for the individual to take advantage of those things related to the humanities in relationship to cultural opportunities.

Since the Older Americans Act is a pivotal piece of legislation which takes leadership in determining the way in which a significant portion of our population for the 21st Century will be treated, it is reasonable to set the stage for addressing the issue of whether populations melt. The "melting pot" concept is implicit in the Older Americans. . . that as people age, they are homogeneous and that we have a society of assimilated older persons There is mounting evidence that we are not moving toward a more assimilated society, but on which is less willing to become assimilated and amalgamated. In serving older people, there is now the facet acknowledgement that diversity is significant. For example, ethnic preference is allowed in nutrition programs and in senior center activities. Mounting evidence suggests that there is more support for co-existence of cultural, ethnic and racial groups, with each supporting the other when appropriate and respecting the values and norms of other groups. Several scholars have talked about diversity and the positive as well as negative aspects of diverse cultural groups being recognized for their worth in a complex society.

It would be well for the Older Americans Act, as it is reauthorized, to explicitly acknowledge that diversity has positive qualities. In order to understand and further operationalize diversity, it is suggested that the emerging concept of "diverse life patterns" be included in the language. Diverse life patterns recognizes the differences of older individuals and their collective life experiences. It does not assume or impose the need for comparisons across cultural, racial and ethnic groups. Policymakers, planners, educators, researchers and others are then free to look at the specific needs of targeted populations and develop programs and allocate resources based on the specific circumstances of those particular groups. This in essence reduces many of the problems associated with trying to generalize services and programs targeted populations which have very little in common.

Targeting to diverse aged populations is the key to ensuring that older people in greatest social and economic need receive the attention needed. Targeting refer not only to race and language differences, but to the higher proportion of poverty among certain minority elderly groups. Recent efforts on the part of the Administration on Aging to better understand how targeting can benefit all older persons, and specifically those in greatest social and economic need, has shown that targeting is one way of ensuring that services are more equitably distributed. The National Resource Center for Minority Aging Populations conducted a nationwide survey in 1989 which indicates that there is a willingness on the part of the aging network to develop targeting formula which will provide intrastate guidelines for ensuring a reasonably equitable distribution of resources. In order to support the efforts of states and to ensure that there are sufficient resources, the reauthorizing language should include very specific guidelines for developing targeting formulas. The formula ranges now include everything from very simple one sentence statements to very complex multiple paragraph statistically ladened statements. This induces confusions and sometimes a since of inequity across states with regard to the ultimate distribution of services. In simple terms, the authorizing legislation should be very clear by providing specific guidelines for standardizing funding formulas.

To stem the tide of the burgeoning number of older persons who fall into the "have and have not" categories, it is important to become much more clear and directive with regard to targeting services. Specific guidelines along with the mandate to target services to minority older persons and those in greatest social and economic need would be a major service to aging program administrators throughout the aging network.

In order to bring about changes in the aging network and the provision of services to targeted populations, it is imperative that greater emphasis be put on education, training and research. Education and training are the pivotal points around which change must occur. The past 10 years has witnessed a ravaging drought in support for educational and training programs in gerontology. The major infusion of support has been at the doctoral and post-doctoral levels. The deficiency at the undergraduate level and pre-doctoral level has been most damaging. If we are to have well educated and trained personnel to serve the diverse aged population, major responsibility for that cadre of individuals must come from the public sector. It is ironic that the fastest growing segment of the older population is within the ranks of minority older persons, while at the same time there are fewer and fewer individuals who have the opportunity to receive training to serve older persons from similar cultural backgrounds. We constantly bemoan the fact that we do not have qualified bilingual and bicultural administrators and service providers. If we do not support training and educational opportunities for these individuals, it will be virtually impossible to have sufficient numbers to begin to meet the growing need. There is a commensurate need for more basic and longitudinal research to understand the changes occurring within the targeted populations.

There are many key issues which have an impact on the quality of services and the quality of life of targeted populations. The following is a discussion of only a representative sample of some of these issues:

1. Home Care - More rather than fewer older people are remaining at home and are returning home earlier after a major illness. Minority older persons have historically been cared for, to a greater extent, in the home environment. This circumstance calls for greater support for the home bound. Thought must be given to how to increase ways in which assistance can be given with ADLS (average daily living supports). For example, more resources can be made available for assistance with housecleaning, shopping and personal care.

2. Transportation - Transportation has plagued many targeted groups for a long time. Assistance continues to be needed for receiving adequate medical care. Consideration must be given to devising ways of funding transportation costs, even with Medical, there are gaps in transportation coverage.

3. Employment - Emphasis on employment for the elderly is beginning to shift toward the actual inclusion of older persons in the labor market or the reentry of older persons into the labor market. Of major concern is the fact that many older minorities in the targeted population groups have not had good work histories and therefore would not be among those who would necessarily be employed based on previous experience or rehired on a part-time basis whether full time or part-time, into their

previous job environments Further, recent emphasis on volunteerism for older people is not as widely received by elders because of an increasing need for supplemental or basic income. Many older people in the targeted populations can not afford to volunteer nor do they come from backgrounds where volunteering to work in formal programs is the norm.

4. Retirement - The language currently uses the concept "retirement". Retirement for the mainstream older person has a very specific meaning which is generally understood by most. A high percentage of older minority and culturally diverse individuals do not have the benefit of experiencing retirement in the traditional American sense. If we continue to base activities, programs and benefits on retirement, many diverse cultural groups will be completely ignored. Since retirement is based on the presumption that one has moved away from gainful employment in a formal or informal manner, many older persons do not fit the mold. The language in the act should begin to refer to quality of life after work. The inference is that there are programs, benefits and opportunities that are available after individuals reach a point where they no longer need to work, on a full time basis, to acquire the necessities of life. Retirement is becoming a "non concept," in that even those with formal careers are not following the traditional path of work and then retirement. The accepted trend in today's society is one of multiple careers, occupations and jobs. Significant numbers of older minorities do not have careers or regular occupations. Many have a series of jobs, often without benefits, and must continue to work until they are no longer physically capable of continuing.

The above issues represent only a few examples of issues that directly shape the direction and fate of those included in the targeted populations.

The Older Americans Act, as amended in 1987, has many positive aspects which lay the groundwork for enhancing services and attention to targeted populations. The reauthorization in 1991 provides a golden opportunity to put forth legislation that will set the tone for a platform that will serve as the framework for moving through the '90s and into the 21st Century.

In conclusion, further efforts should be made to reach and serve all targeted populations by understanding and developing programs based on diverse life patterns and not the melting pot or assimilation ideas. Title I on the Act should include language which clearly states that preference will be given to older people with the greatest social and economic need.

Thank you very much for the opportunity to share some ideas that may be useful in enhancing the Older Americans Act Reauthorization.

Mr. SOLOMON. Thank you, Percil. That was a wonderful start to the workshop series. I think you really hit on some of the key issues in the target population that we want to discuss more on the floor later.

Our second panelist is Dr. Robert B. Hudson, Professor of Social Welfare Policy, Chair in Social Welfare Policy at Boston University. Dr. Hudson will deal with the issue of service delivery. He's the former president of the Massachusetts Gerontological Association and former chairman of the Gerontological Society of America, Section of Social Research, Planning, and Practice.

I might mention here too that the C.V.s of all the speakers, I believe, are in the package so if you want to see—they're extensive. We could spend all day. I could not read all the things they've written.

Dr. Hudson is also no stranger to the Senate committee. He testified in 1981 before this committee surprisingly enough on the reauthorization of the Older Americans Act. Dr. Hudson received his B.A. degree from Washington and Lee University and his Ph.D. in political science from the University of North Carolina.

Robert, it's nice to see you again.

STATEMENT OF DR. ROBERT HUDSON, PROFESSOR, SCHOOL OF SOCIAL WORK, BOSTON UNIVERSITY

Dr. HUDSON. Thank you very much. I appreciate the invitation and the chance to revisit a piece of legislation that I spent a lot of time in the 1970's working on. I am pleased to comment now that reauthorization is being addressed once again.

It is a bit of a challenge to talk about services to the presumed exclusion of populations and organizations given how the seminar is structured, but I think I can be true to the spirit of the organization that has been set forth.

I want to briefly address some of the on-going issues that have been around the Older Americans Act for 25 years, speak to some notable if not monumental changes that have taken place in the world of the Older Americans Act in more recent years, and then speak briefly to some issues and options that I think will form the gist of what we may all do when the workshop opens up a bit more.

Let me speak first to the on-going issues. First of all, the Act in many ways has been and continues to be, with the best of intentions, extraordinarily vague. Title I, as the chart shows,[3] has 10 objectives that are laudable but totally beyond the reach of any of the organizations that operate under the Older Americans Act.

The 19 supportive services listed under Title III are all fine services but again with the not insignificant but nonetheless not enormous appropriations under the Act, those too, cannot be done real justice.

On the other hand, we also have had in recent years increased earmarking. You have broad instructions on the one hand and then very specific mandates on the other. Thus, the State plans for example now require services and efforts involving rural populations, ombudsmen, nutrition, alterations and renovations, legal services, elder abuse, non-English speaking outreach services, people with severe disabilities, training, social, and economic needs especially minorities, as Percil was noting, and services consultation, and some other areas.

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[3] See appendix, p. 185.

Thus, there's broad intent, specific earmarking, and it's an odd mix for those charged with administering programs under the Older Americans Act.

The second issue is what has long been called the twin mandates of the Older Americans Act. On the one hand, there has been sort of an inward looking services delivery, services oversight, services development mandate. On the other hand, there has been an advocacy pooling and tapping, and, what Bob Binstock called years ago, leadership planning effort, which would essentially have AOA, the State and area agencies looking beyond their immediate confines. This contrasts with the former mandates which tends to have them charged with moving toward setting up or overseeing some kind of a delivery system of their own.

There have been lots of pressures and incentives earlier on for the agencies to engage in more of the inward-looking activities. In many parts of the country, it may be both an easier and more appropriate effort to build a services network as best they can with limited resources rather than go out and do serious advocacy efforts elsewhere.

A next issue would concern eligibility, an issue which Percil certainly has spoken to. The tension here is how on the one hand to be true to the spirit of the Act, which is that all persons over age 60 should be eligible for services and yet meet the more specific strictures elsewhere in the Act that low-income, socially and economically vulnerable, and minority populations should be especially served. You may recall in 1987, an effort to accomplish this by proxy by raising the eligibility age from 60 to age 70 level was resoundingly rejected.

A next issue concerns problems related to the vertical structure under the Older Americans Act where various mandates are given to the Administration on Aging in Washington and in the regions and others given to the States and the area agencies. As for the Washington mandate, AOA is charged at least nominally with dealing with Title I and all of its laudable goals and yet it is also charged with seeing to it that some of the more specific earmarking and specified things are undertaken as well.

At the State and area level, they too struggle under some of the ways in which the Act is organized insofar as services are concerned. At the State level they are indeed to devleop and administer a State plan, but formally at least, a State plan is supposed to be built on top of the area plans which they receive. So if in fact a State plan were to be nothing more than the sum of the area plans underneath it, that logically says that the State agency has no discretion and no autonomy of its own. In reality however that is far from the case because in addition to building their plan on top of all the area plans, they are also supposed to engage in advocacy activities at the State level, serving as an effective and visible advocate for purposes of the Act.

At the area level, the services come up a little bit differently. The area agencies are charged under the Act with developing a comprehensive and coordinated services system yet their list of mandated services varies from that of the States, the areas being charged with in-home access, legal, adult day care, case management, elder abuse, involving long-term care providers, Alzheimer's victims associations, mental health services associations, and higher education.

There is nothing wrong with any one of these, but when I spent a week in Albany, MO, with a staff of four covering 14 counties, they simply weren't into all of these with all the effort that the formal language would suggest they should have been.

Reviewing this first section, on the one hand, the Older Americans Act has been too vague. On the other hand, it's probably been too specific. In some ways, it's probably been too mundane as to what specific services should be made available to individuals. On the other hand, it has asked too much. These agencies under these auspices could not in most instances come close to meeting the total spirit of what the language says, understanding that most would know that some of it is a bit rhetorical.

The agencies have also not been able by and large to establish on their own comprehensive and coordinated service systems within their States and areas. That's not to say there are not good services and there are not some systems. But it is not the case to say that we have come close to meeting that service system mandate, although this is certainly not necessarily to fault those who are charged with that task. The legislation itself may be at fault, and certainly the appropriations and other resources these agencies have at their disposal leaves something to be desired.

Having mentioned the down side here, I should add that the Older Americans Act has made some remarkable contributions in terms of both service delivery and to the capacities of agencies operating under the Act. First of all, it established the agencies and in a retrenchment era—post-Great Society, post-Jimmy Carter, two terms of Ronald Reagan. To have 700-plus agencies around the country, even with all the vagaries that may be associated with their mandates, is no mean feat.

It is a set of agencies that symbolically and in fact serve some very important purposes. The fact that they are federally authorized provides the State Units and the Area Agencies with a legitimacy in standing that most proprietary agencies wouldn't have and that most private nonprofit agencies wouldn't have. It is a resource that can't necessarily be counted in dollars but I think is of great importance.

One program that has both been very useful to older people and has been very useful to furthering the organizational place of the agencies responsible for implementation has been the nutrition program. The nutrition program provides congregate and in-home meals and those indeed are valuable. The meals are also useful politically in that they can be counted. People can be seen. Benefits are concrete and it does a number of useful things along that line.

Beyond that, based on the studies I've been associated with and people I've talked to is that the nutrition program has served a remarkable capacity-building function for area agencies around the country, particularly in small towns in rural areas. The nutrition program made available the money and the staff to in fact go out and put an extra person in the senior center, to make sure that somebody could serve part-time as a recreation director. Even more important, it made it possible for the director of the area agency to sit down with a county commissioner or go around and show a local political official or a prominent citizen that indeed this Older Americans Act program and this agency really did do something useful.

Local officials and local notables often like to see tangible results, and the nutrition program provided very tangible and very visible results. Again, I want to emphasize the importance the program has had well beyond nutrition in, in fact, serving the organizational needs of the agencies involved.

Let me turn then to what's happened more recently. There are some changes and I want to take a minute to run by those so we can have the conversation up to date.

The macro changes you're familiar with. Let me just list them because they all suggest what the new world of the State and area agencies is like. The elder population growth you know about. The enormous growth in the old, old population and the associated levels of frailty you know about. You know the U.S. population over 85 is doubling every 20 years. You are aware of a big and growing nursing home population and efforts to keep that population from growing more quickly.

You are well aware of concerns that virtually every State in the country (except Arizona) has about Medicaid. Medicaid essentially is the largest single item in virtually every State budget these days, and the largest single item with that is long-term care expenditures.

You are aware of the new entrance of proprietary agencies and various chains of one kind or another getting involved in aging and long-term care activities. Finally, you are aware that, under various cost constraint initiatives, particularly the DRG system, early hospital discharges have put great pressures on community-based agencies dealing with older people.

What all this has created is a need to divert clients, to demonstrate alternatives, to probably waive selected requirements under Federal law, and to find some kind of an administrative structure that could begin to address at least part of these issues.

It's in that world that I would come back to agencies operating in association with the Older Americans Act and speak to the emerging role that many of them are taking in home and community-based care. That is an area of growth that has a certain imperative to it, and the issue is how is it going to be conducted and who is going to do it.

We know that Medicaid historically has been institutionally driven. We know that Medicare obviously is very much acute-care-based. Certified home health agencies are obviously very much part of a medical model. Mental health and mental retardation departments have also been institutionally-based and indeed many of them have had relatively little interest in the problems facing older people. Public health departments are very much involved in prevention, certification, and many activities that do not directly pertain to the establishment of home- and community-based care systems.

What this makes possible and what in fact has happened in a growing number of places is that the aging network is looking to this whole world of community-based care in a more encompassing way than it either could have or needed to prior to the early 1980's. These agencies under the Act are community-based, they're aging-focused, they're in place, they're in State capitals, and they're located reasonably logically around the States. These agencies are staffed with growing numbers, but more importantly, staff quality has grown dramatically, including more personnel with knowledge of budgeting, policy analysis, planning, and a series of reasonably hard policy analytic functions. As this network and what it might do grows in stature, it is attracting serious personnel and serious attention in most parts of the country.

We don't have time to go into this but what we find in a number of States—Illinois, Wisconsin, Massachusetts, Oregon, Arkansas—are some very serious efforts around community-based care. These efforts are growing up essentially involving Older Americans Act agencies and there seems to be further development in the offing in that direction as well.

Let me move on to say that with regard to the Act itself there are concerns about the capacity of agencies in all parts of the country to get centrally involved in home and community-based care. We certainly know that there are numerous other actors that are involved in those efforts as well, and their relative place to those of these agencies would have to be looked at.

As to reauthorizing the Act, there are two serious issues I would quickly note. One that's been around for the last 2 or 3 years is whether or not these agencies should get involved in case management functions. Is that a direct service which is essentially prohibited by Older Americans Act language for area agencies to be involved in, or, is it an indirect service, that is, the mobilizing of more direct services that they could indeed be involved in? That issue needs to be resolved.

A very thorny issue, particularly in light of the rise of proprietary efforts, is that some area agencies around the country interested in home and community-based care are finding themselves exploring the idea of fee-for-service. This would entail going into the private market as well as serving their traditional clients. This, in turn leads to concerns about the so-called "creaming" phenomenon, where an agency would serve the more affluent or the less-frail clients. The counter argument holds that if agencies are starved for resources in some places then the only way to in fact legitimately meet their traditional mission would be to have additional resources from the private sector available to them.

Let me skip ahead here to make three final points and then I'll wrap up. Under this new late-1980's, early 1990's world, people concerned about what should happen to the Older Americans Act need to be very mindful that the world out there is much more a "horizontal" world than it is a "vertical" world. The traditional vertical, top-down, categorical grant programs are not as central as they may have once been in this world of new federalism and limited money. There are big new public dollars out there addressing community-based long-term care but the point is, many of those new dollars are State dollars, not Federal dollars.

A number of the States I enumerated a minute ago have very considerable State-level efforts. Massachusetts receives probably a total of $18 to $20 million Older Americans Act a year and puts $120 million of its own money into home care programs. It is those State-level or horizontal aspects I think have to be recognized by those who are getting involved in reauthorization.

I would suggest that the individuals charged with reauthorizing do not over-categorize. The tendency given the politics of interest group liberalism to recognize every particular interest that comes across the door needs to be resisted. I appreciate that it's hard to resist and I appreciate that many of the specific concerns are very real.

In 1987, there were major efforts made on behalf of developmentally disabled older people to be recognized and such an effort raises a classic public administration issue. But the larger point is that to the extent that specific service dollars are earmarked for specific populations, meeting larger functional needs will be increasingly difficult.

On the other hand, some people may have speculated about whether or not we should just get rid of the Older Americans Act and turn it into some kind of a block grant, perhaps fold it into the Social Services block grant. I would resist that option as well. I think as I said before, a very useful network is in place. It brings the legitimacy of the Federal presence and, while the dollars are limited, they do in fact provide leverage for able and capable administrators at the State and local level.

I would totally concur in Percil's comments about the disadvantaged. If anything, I would try to strengthen that language as he would, and we can talk about that later.

My final point is one that we haven't talked about here. Nobody has talked about Title II of the Older Americans Act in about 12 years.

Title II is the Administration on Aging Title, the Federal administration of the Act. I think the time has come—and I was involved with a Gerontological Society of America project speaking to this issue—that resources and heightened visibility be given to AOA. These would be not so much to run a traditional social services grant program but in fact, to do two things: to have the visibility and authorization to work with people from HCFA, Public Health, and other relevant agencies in ways in which they can help State and area agencies do what they need to do with regard to home and community-based services and second, to have the resources and personnel to enable it to become a serious policy analytic resource for people in Washington and elsewhere interested in some of these issues.

The language is certainly there. The language of Title II is as encompassing as the language of everything else and it would be nice to see personnel in place able to bring about.

Thank you very much.

[The prepared statement of Mr. Hudson follows:]

REAUTHORIZATION OF THE OLDER AMERICANS ACT

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OLDER AMERICANS ACT REAUTHORIZATION SEMINAR

U.S. Senate Select Committee on Aging

and

U.S. General Accounting Office

Mr. Chairman, I am pleased address this initial seminar concerned with reauthorization of the Older Americans Act. I have studied the Act and agencies operating under its auspice since the early 1970s. Many of the issues that confront those involved in the 1991 reauthorization process will be familiar ones, in some instances dating to the Act's initial passage in 1965. Other concerns have arisen more recently as the size and needs of the older population have grown and as the settings in which the Act is implemented have changed.

I have been asked to direct my remarks to service issues under the Older Americans Act, specifically whether legislative intent is being met and what alterations might be in order to enhance service delivery. In responding, I will address in turn: (a) difficulties in determining what, if fact, is the "legislative intent" for social services under the Act; (b) wide variations and changes in approach to service system and delivery questions that exist around the country; and (c) different options about policy intent and structure that the Congress might consider under the Act.

1. Services and Legislative Intent

a. Legislative Language

Since the Older Americans Act enactment, there has been a widespread belief that the formal language of objectives, purpose, and intent has been so encompassing as to provide little guidance to those charged with implementing it. The 10 objectives in Title I range from adequate income to suitable housing to opportunity for employment and to efficient social services. The commitment reflected here is immense, totally beyond what agencies once funded to the tune of $7.5 million nationwide could hope to accomplish.

The 18 supportive services enumerated in Sec. 321(a) are more specific in setting forth functional concerns (transportation, health, recreation, crime prevention, abuse prevention, preretirement counseling) which services should be "designed to" address. Nonetheless, it is hard to conceive of a service which could not be included in this listing (even apart from item 19 reading "any other services").

Language that is more useful for operational purposes is found elsewhere in Title III, specifying functions in which state and area agencies should be engaged. The longstanding difficulty here, however, has been that these functions are not necessarily compatible. Key services language found in Sec. 301 states:

> "It is the purpose of this title to encourage and assist State and area agencies to concentrate resources in order to develop greater capacity and foster the development and implementation of comprehensive and coordinated service systems to serve older individuals . . . ."

A somewhat different mission is suggested in Sec. 305, namely, that the state agency should "serve as an effective and visible advocate for the elderly . . . ."

Taken together, these three legislative sections have framed what is now the 25 year debate around what is it that state and later area agencies were supposed to do in order to enhance the wellbeing of community-based elders. To what extent was the operational mission to be (a) the contracting for and/or delivery of social services; (b) development of a comprehensive and coordinated services system; or (c) an advocate for elders with the public, legislators, and other agencies? In some discussions, the first two have been combined so that the debate is between "services development" or "system creation" on the one hand and "institutional change," "leadership planning," or "pooling and tapping" of resources on the other.

Over the years, this multiple mission statement has caused a variety of concerns. First, it simply may be too much to expect any agency to make significant accomplishments in three different directions. Second, it has generally been felt that incentives for state and area agencies lay more in the services delivery/services system arena than in the advocacy one. Constituencies as varied as local publics, political officials, and oversight agencies wish to see concrete, visible, and measurable results of agency activity. Discrete social services -- and especially congregate nutrition services -- fit that bill quite well. On the other hand, meaningful advocacy efforts may be more confrontative ("we want you to do more for the elderly"), less visible (joint screening teams, joint committee work), and have longer time frames. Thus, it may be that the presence of multiple mandates provides a way to downplay certain types of activity.

b. Policy rationale behind OAAct services

Lack of precision has marked the Older Americans Act on each of four key dimensions: eligibility, benefits, administration, and financing. This has both made it difficult to assess and value activities that have been undertaken and has had the effect of finding fault with system actors when the system itself has been flawed.

Eligibility issues have centered on who over age 60 should be served. Means-testing as a basis of determination of need has been firmly resisted since the Act's inception. In 1987, an attempt to concentrate resources on the functionally impaired by raising the age of eligibility to age 70 was also vehemently opposed in many quarters. Instead, minority, low income, and persons deemed to be economically and socially disadvantaged have been targeted over the years. Evidence suggests that in most areas, these groups have been more heavily served, but the issue of who should be principal beneficiaries of the Act's services continues to be poorly articulated.

The Older Americans Act is based on a services strategy, which presumes a particular problem and response definition. Individuals are determined to have problems in certain aspects of their lives, and the Act will make possible the provision of discrete service units to address them. This approach precludes a different view that suggests that the problem lies some place other than in the individual (retirement policies, air pollution, inadequate income).

It has been argued, as well, by critics on both the right and left that a services strategy creates a massive provider constituency that looks primarily to its own prerogatives and, in so doing, precludes older persons from designing a response to whatever their concerns may be.

In administration, the Older Americans Act embodies problems of responsibility and decision-making frequently found in the U.S. federal system. The Act -- however loosely -- sets forth purposes and objectives for program implementors to pursue, but mandates, as well, a host of hearings, committees, and plans at the state and local level designed to make local efforts responsive to local concerns. By design and circumstance, the passage of time has seen decision-making responsibility devolve to the state and area agencies. While that trend has presumably made planning and funding more responsive to at least certain parties, it has made it increasingly difficult for the Administration on Aging to speak of national efforts, patterns, successes. Whether what some would call the pretense of national direction should be removed once and for all or whether current or added categorical strictures should be maintained will be addressed in the third section.

Federal funding under the Act grew dramatically in the 1970s, and has remained quite constant during the 1980s. Of perhaps greater importance is the enormous increase in state-level funding that has developed in recent years. Massachusetts spends over $100 million in state money through its Area Agency/Home Care Corporations contrasted with less than $20 million in Older Americans Act funds. Significant state-level funding combined with loose federal language clearly shifts the locus of decision-making downward.

The formal language and underlying rationale of the Older Americans Act have long made goal-setting and evaluation difficult. Over time, changes in the legislation and in the states have rendered the Act increasingly permissive in constraining the choices made by state and sub-state actors.

2. Issues in Older Americans Act Implementation

The world in which the Older Americans Act is implemented is both diverse and changing. Diversity marks the settings in which service and advocacy activities take place and the make-up and orientations of the agencies themselves. The changes center on perceived problems, funding shifts and constraints, and developments in different societal sectors

a. Diversity

New York City and Albany, Mo. are very different places yet they both are homes to Area Agencies on Aging. Key dimensions include population size, geographical size, agency auspice, state of location, monetary and staff resources, and political culture. Given these levels of diversity, Roger Cobb and Charles Elder's contending that the Older Americans Act is "less a statement of policy than a sanction to search for policy" may be a good thing.

Site research I conducted in four PSAs during the early 1980s speaks to the diversity of state and area agency environments and implications of that diversity for the Older Americans Act. The project centered on the capacity-building strategies of Area Agencies, i.e., their ability to develop autonomy, set goals, mobilize and parlay resources for future efforts.

As others have been, I was struck by the conditioning effect of the environment in which the agencies were working. This is sometimes referred to as "environmental accommodation," but, said more positively, the effective agency director is one who understands the setting and turns it to his or her purposes. The director in Lancaster, PA knew that the county commissioners were most concerned about efficient administration and "bang for the buck." In convincing them that the agency was being run efficiently, he got their backing for additional agency efforts. A senior center in St. Joseph, Mo. prided itself on weaning itself of federal dollars, and the agency was able to allocate those dollars elsewhere. Back in Lancaster, the community would not allow the III C 2 in-home meals program to be implemented because it represented federal intrusion into the home and because 100+ churches were already providing such meals; thus, the Director worked a swap of III C 2 money for III B money with another Area Agency director. Different cultures, different strategies, different successes. Trying to impose or reimpose some singular national strategy given these variations would be daunting.

Having noted the diversity, there are two important points to be made about the place of the Older Americans Act in the workings of these agencies. Most obvious is that, without the legislation, these agencies in small town and rural America would not have existed. As to the question what would happen if the money were reduced or withdrawn, in no case was there any assurance it could be replaced. Roads, schools, police, and fire consume local budgets; it's nice to serve older people, but with someone else's money.

Area Agencies in the study also valued the categorical protections of the Older Americans Act. This was especially the case where an Area Agency was housed in a Council of Government covering 14 counties and incorporating a host of planning and service agencies. Without requiring a single purpose agency to administer the federal program and in the absence of the age-based restrictions, pressures to use funds for unrelated purposes would have been near irresistible. In this setting, the counterargument that these and other funds could have been pooled for truly comprehensive planning would probably not have been borne out. Actors looked to funds for their needs and services; rational planning did not appear to be high on anyone's list.

A third utility of Older Americans Act provisions centered on the nutrition program. In three of the four sites, the III C program enabled agencies, not only to provide meals and socialization, but served as well as an organization resource to further the agencies' work. The staffing, physical space, and community and political involvement the nutrition program brought served as important building blocks. In rural areas, nutrition allocations were by far the largest source of hard currency. In rural Missouri, the nutrition sites were at the heart of "focal points" set up in the PSA numerous small towns. In Tennessee, the director said that the nutrition program had served as the "carrot" that helped in going out and demonstrating to the COG directors (of whom there were over 50) that aging programs were bringing real benefits and enrolling their support for additional efforts.

For capacity-building purposes, the Older Americans Act assumed symbolic utility for the agencies. Even beyond particular categorical protections and even beyond the dollars themselves, the message was that there are funds (and opportunities) available directed toward older people and only for older people. These agencies were not able to develop "comprehensive and coordinated delivery systems," but these monies and organizational resources are simply not requisite to that charge.

b. Changes

In most of the nation, the Older Americans Act was responsible for identifying older persons as an important service constituency and was important in the 1965-75 decade in getting the public and public officials alike to recognize problems confronting them. Over time, however, the volume and type of needs have changed in important respects. The Act has changed relatively little, and the important question arises as to how well suited it is to these new realities.

New challenges and strains started hitting the aging network in the late 1970s. The need for policymakers and others to recognize the presence of older persons had been addressed. The emerging concern became how would we go about meeting what was to be the increasing needs of a growing population. Administratively, area agencies in many states were drawn more tightly into state level administrative networks; previously autonomous agencies found themselves as agents of state level policy and programming. Agencies that had been very much in the social services world found themselves drawn into the health world as the older population aged, nursing homes filled up, and hospitals discharged earlier. In many states, area agencies went from being big players in small ponds (the Older Americans Act was one of the few remaining 1960s categorical services programs) to small players in the potentially enormous world of Medicaid and Medicare, VNAs and VAs.

More recent has been widespread interest among area agencies to move from the world of social service development and oversight and into brokering clients into and through the larger community-based long-term care system. At least three factors account for moves in this direction. First, the increasingly frail client that area agencies see has both greater service needs and less ability to negotiate the system than did earlier clients. Second, other agencies were undertaking case management, by whatever name, toward moving clients into their service systems. And, thirdly, having frequently found the charge to develop a comprehensive and coordinated system an insurmountable one, area agencies felt themselves well-positioned to focus on clients and referrals rather than agencies and services. To area agencies, this seemed an important and logical adaptation of their work to new realities.

Opposition to an extended case management role, initially from AoA, was based on two traditional views of what "Older Americans Act agencies" were all about. Toward enhancing the planning and advocacy role, the legislation had long held that area agencies were not to engage in direct service provision unless they could demonstrate that services could not otherwise be provided. During 1987 and 1988, AoA and N4A debated whether case (or care) management was, in fact, a direct service, the latter insisting that it was an "indirect" service fully in keeping with the spirit of the earlier mandate. Many others would agree that assessing, screening, brokering, and monitoring are functions conceptually distinct from health and social service provision. Perhaps more important is that in the "new world" spiraling heath care costs and growing service demands, case management is a systems function that must be performed. And because of their longstanding presence in local communities both as advocates and as agencies that do not engage in direct service provision, they felt themselves especially well-suited to the task.

A second objection centered on who, in fact, would be "case managed," and where payment would come from. The aging network has taken seriously the charge to target socially and economically vulnerable clients. Now, would area agencies reduce their commitment to these persons and the public funding that supported that work in order to move toward fee-for-service and other third party reimbursement? Critics speak of two-tier systems and abandonment of clients in need. Proponents counter, arguing that in light of flat or declining public funding, serving a broader client base will enhance rather than reduce their ability to serve disadvantaged persons. They argue, as well, that the world in which they are operating is a different one than Older Americans Act architects could have envisioned. There are new competitors -- some with no pretense of assisting the vulnerable -- now in the field, and they cannot legitimately address these new concerns constrained as they are by restrictive regulation and an eroding funding base.

3. Issues and Options

In my comments to this point I have (a) spoken to mandates, issues, and strategies that marked aging network development under the aegis of the Older Americans Act and (b) indicated that new population needs and changing health and social service settings have raised a host of additional issues. In light of these developments let me conclude by commenting on three very different courses the Congress might follow during the reauthorization process.

a. Incremental changes. Leaving the legislation largely unchanged will foster increased diversity in the aging network. These agencies have been different from one another since their origins, but, with the passage of time, the Older Americans Act has become relatively less significant in shaping their direction.

Growing demand, escalating costs, and new actors have pulled many agencies into different worlds than those of 10 or 15 years ago, and the size and ambiguity of the current Older Americans Act is of secondary concern to the aging network agencies confronting these new realities.

Agencies that feel competitive pressures and which have dynamic leadership able to tackle and even take advantage of these developments will do so largely independently of Older Americans Act strictures. Agencies that by choice and circumstance continue to be relatively free of hierarchical pressure, garner support for overseeing social service delivery, and serve as focal points for community elderly will continue along their path, displeased with the growing list of legislated groups to be served, but able to meet community demands and preferences nonetheless.

As to the core charge to develop comprehensive and coordinated social service delivery systems, the first set of agencies will find such a strategy ill-suited to the world with which they are now faced, and the second set will be unable to muster the resources to move notably in that direction. Over-dichotomizing conditions a bit, in one world of aging agencies, there is a plethora of services, and the issue is finding the most useful and viable role to play. In a second world, there is a paucity of services, but there are not the resources with which such a system could be built.

b. Block grant alternatives. The option of "blocking out" the Older Americans Act has come up in recent reauthorizations. If the mission is multiple, success is uneven, and accountability hard to come by, what purpose does the Act serve standing on its own? Whatever the gains of blocking it out, my sense is that there is probably more to lose than to gain. The dollars are relatively few, and opening them up to added demands would diminish their effect further yet.

More important is the organizational purpose that at least modest categorical protection provides. Core budget and function may simply protect a weak agency and perhaps inappropriately, but that same core provides an important building block to an agency determined to garner additional support, locate additional resources, and devise innovative service strategies. This is the true organizational success of the nutrition program, and it holds to a lesser degree for provisions and funding under the Act in general. Used appropriately, categorical restrictions provide support but not a crutch.

C. A care referral/management system. This is an intriguing option that, as noted earlier, is in many ways congruent with the new mosaic of older clients, new providers, and multiple funding sources. There are several issues that should be addressed as network agencies and others consider this option. Are a critical mass of area agencies willing and able to become centrally and quite exclusively involved in these efforts? Given the growing number of players keenly interested in performing these functions themselves, does the network add to the clutter or help clear some of it away? And, while moves in this direction would be ambitious for most area agencies, for others management without delivery functions might not be enough. The players are so big that vertical integration might be a necessity at least in some settings. The Older Americans Act would need to be modified accordingly.

The time may be at hand to give the Act a really thorough review. The Older Americans Act's clear accomplishment is to have spawned agencies that in most instances are well-established -- if not always widely recognized -- actors in their states and communities. Broad categorical protections will provide sufficient support to most. Thus, further easing of internal restrictions -- such as that permitting some shifting of funds between the nutrition and social service categoris -- might well be in order. To follow a different direction toward imposing a new national direction -- such as case management -- would encounter resistance and diversity that are both quite considerable. That does not deny that some version of case referral and management may be well-suited to the contemporary circumstances of many aging network agencies, but garnering nationwide support and compliance will be a formidable task.

Thank you.

STATEMENT OF DR. ROBERT BINSTOCK, HENRY R. LUCE PROFESSOR OF AGING, HEALTH, AND SOCIETY, CASE WESTERN UNIVERSITY

Dr. BINSTOCK. Thank you, Mr. Solomon and friends.

I'm honored to be invited to present my views this morning.

I'm going to propose a new role for the network of agencies funded under Title III, perhaps at no additional cost—a role as a highly visible, nationwide, inter-community network of Aging Resource Centers. The acronym would be ARCs.

This network would be something to which any older person and their families can turn to for effective help.

Now before spelling out what these ARCs would do, I would like to briefly put this proposal in context. As my colleagues have intimated and said directly, during the past 25 years the Title III network has been an excellent vehicle for identifying and emphasizing challenges of an aging society, for developing and exemplifying strategies to cope with those challenges, and for providing help to millions of Americans. But the political environment that nourished this program is no longer with us, and hasn't been for some time.

As Title III funding has remained virtually level during the past decade, congressional leaders and many members and leaders in the network itself have persistently asked whether the funds appropriated for Title III might be used with greater leverage or in a substantially different fashion. But legislative changes in Title III throughout the past 15 years have been minor. And as this Committee on Aging has observed regarding the Act, "It is clear that Congress will need to go beyond incremental changes in reforming the Act to enhance and further the goals it set for itself and the Nation back in 1965."

During the 1991 process of reauthorization, the network needs to be examined in the light of some very basic issues. Could the objectives of the Act and/or the challenges of an aging American society be better met by expending Title III resources in a different fashion than they are now? What is presently distinctive about the network that has been generated through Title III? What is the most useful role it might play?

Most though not all of the services that have been generated, developed, advocated, and provided by the network during the past 25 years are now being provided by a multitude of public, nonprofit, philanthropic agencies and profit-making agencies. As one example, estimates are that there are well over 10,000 home care service agencies in this country alone. Most services to older persons are now provided on a much larger scale through other auspices than can be provided through the limited funds available to the network, both through the Title III appropriations and what it gets from State governments. (The major exception is the Title III nutrition programs.)

What seems to be missing, however, for most older persons and their families is personal knowledge about such matters as how and where do they undertake the process of getting help, from which of many agencies can they get help, and on what terms?

What kinds of help will they get, and will it be appropriate and effective?

I can tell you that over and over again, every time my name appears in a newspaper or magazine for one reason or another, I become one of these ARCs—an aging resource center—over the phone or through the mail. For example, about 3 weeks ago I had a piece published in the *AARP Bulletin*. I received about 200 letters, with half of them seeking help for problems. In the first few nights, I felt like I was running the Larry King Live Show at my house, because of phone calls seeking help from Green Bay, Wisconsin, Seattle, and all over the country.

These people did not know where to turn to for effective help. The agencies may be there ready to help, but I suggest to you that people don't know what are their area agencies on aging, and they don't know about a lot of these other things. For example, the marketing of a multitude of agencies through acronyms is unbelievably mystifying in itself. The acronyms keep people from knowing what these agencies do. In Ohio, for example, we have three programs. One's called PASSPORT. Another one's called COMPASS, and the third's called OASIS. PASSPORT, COMPASS, AND OASIS. Now as far as I can figure out, if you could comprehensively coordinate these three services, you'd have one heck of a trip to the Sahara Desert. That's about what's communicated to me.

I think the most pressing need in our society is for a highly visible, distinctive site in every community that is part of a nationwide, inter-community network of such sites in which older persons and their families can turn to for beginning the process of getting help, reliably. Congress has already recognized this as a pressing need, at least with respect to one disease, by asking its Office of Technology Assessment to provide a report on methods of *locating and arranging services* for persons with dementia—locating and arranging services, not proliferating services.

The Title III network is ideally situated to fulfill the *general* need for this kind of help if it can become more visible in a uniform nationwide fashion. By that I mean, for example, visible in a uniform nationwide fashion as McDonald's is. The network has already evolved into an infrastructure of agencies throughout the country. If such an infrastructure didn't already exist, I think we'd probably have to build one very swiftly.

It's on the basis on this premise, and on the basis of analyzing some of the limited alternatives options which I won't go through at the moment, that I recommend a new legislated role for the network in 1991.

As I suggested at the outset, I propose that the network be converted into this nationwide network of aging resource centers—highly and uniformly visible, easily accessible sites in each community, connections for serving as one-stop sources of intake that older persons and their families can rely upon for getting effective help locally or elsewhere in the Nation.

In this new role, working collaboratively with the full team of private and public agencies in the community, each ARCs would: (1) serve as a source of initial contact and practical information for the client who does not know where to turn; (2) provide emergency responses if the presenting situations warrant; (3) with respect to cases that require complex, nonemergency responses, undertake more extensive information gathering, assessments, planning, counseling, and assistance, and then implement referrals; (4) track progress or referrals at subsequent, prescheduled intervals—3 weeks from now, a week from now; (5) re-intervene if tracking indicates that the referral is ineffective; get them out of there and get them somewhere where they can get real help; (6) regularly analyze and report on aggregate activities in order to provide administrative accountability to AOA, maintain on-going congressional support for the ARCs, indicate areas in which the ARCs need fine-tuning, for example, more in-service training for its personnel, greater capacity, restructuring of operations, and document important gaps in the availability of essential services and inter-agency collaboration in a particular community; and (7) promote in conjunction with State and community leaders, the development of essential local services and inter-agency collaborations that ARC operations have identified as lacking—In other words, work to fill the gaps in local services through system capacity building.

These activities should become the primary or even the sole responsibilities of the network, because this vital role cannot—cannot be fulfilled effectively by agencies that are involved in the provision of or arrangement for direct services.

Three characteristics for this role—high visibility as a community source for help; smooth, on-going collaborative relations with the full range of existing community agencies; and leadership in developing further services and collaborative activities that are lacking—are virtually impossible for an agency to achieve if it's engaged in direct competition with other local service providers, whether those providers are nonprofit, for-profit, or public.

By withdrawing from the role of service providing and service contracting competitor, however, Title III agencies might be able to draw upon their legitimacy as officially designated components of the network to achieve high visibility as a community-intake sites, collaborative working relations among the full range of existing agencies, and leadership in the development of further resources to be available in the community.

Another reason why the network would need to disengage from service provision is that substantial funds would be needed to make an effective transition to and function as an effective nationwide network of ARCs. Unless Congress is willing to increase Title III funding by $300 to $400 million for this purpose annually, funds now used for services under Title III would need to be reallocated and appropriated for the ARC's—whether gradually or immediately—in order to make funds available for the new role and activities.

In addition to the general arguments presented earlier as to the need for ARCs, there are other advantages worth noting.

First, both the probability that older persons and their families will get help and the quality of that help will be improved. The uncertainty of so-called "intake" functions at present—often through police, hospital emergency rooms, physicians' contacts, pharmacists, and generic social agencies—will be reduced.

Second, issues of "means testing," "entitlements," and "moral hazards," would be avoided. Routine ARC functions delineating the natural history of each case would enable clients to receive appropriate help within the framework of existing public policies and philanthropic agencies, or through the private market.

Third, elimination of the network's direct services would, in some communities, reduce redundancy among services now offered by a multitude of providers.

Fourth, as ARCs deal with their clients, a solid ongoing record of gaps in services in each community would be established providing a strong foundation—as contrasted with needs surveys—which the ARC's can use to undertake leadership in developing essential but missing resources.

Fifth, the functioning of the ARCs would build up a strong reservoir of public political support, enabling the network of ARCs to be increasingly effective on a long-term basis and add to the capacity of other agencies to provide help to their clients.

Disadvantages of the new role would be largely transitional. First, if services provided or contracted for were phased out or eliminated, obviously they wouldn't be immediately available and accessible from other sources in the near term. But if there is a need for such services, the leadership and activities of ARC's should lead to their redevelopment swiftly.

Second, a transition to the ARC's role might render obsolete temporarily, many service providing agencies and some personnel of the current network although the latter could easily be reoriented to ARC activities.

In my prepared statement, I've listed a number of prerequisites for effective transition to this role but I'll only reiterate one, the most important, just now. This would be an amendment to the Act by Congress, mandating specifically in its language that the funds now used for services be authorized and appropriated for the operation of ARC's.

If careful costing out of the activities of ARCs indicates that more is needed than I've suggested, or if Congress is unwilling to eliminate existing services, additional appropriations will be needed. I do think, however, the one set of existing services that might be maintained is the nutrition programs. They're not particularly redundant. They're not likely to be developed through other auspices on a widespread basis, although there is a newly-formed National Meals on Wheels Foundation which may ultimately prove to be an effective mechanism for expanding resources available for nutrition programs. In the near term, maintaining the nutrition programs might be an effective trade-off to counter network and client resistance that would be expressed regarding the new role. And congregate nutrition sites could be locations for ARCs, serving as vehicles to promote the visibility and role of the new network.

Without going into further details, I'd like to conclude for now by pointing out that this proposal may seem rather drastic. If so, I offer two observations. First, when I initially surfaced the broad outline of this proposal some 4 years ago, many, though not all, persons in Washington and in the network thought it was outlandish. Since then, many of them have come to support it. I won't implicate them by naming names. Maybe they'll do that themselves through discussion today or subsequently.

Finally, I would reiterate that my experience throughout the country suggests that this is clearly the most useful role the network could save, assuming that tens of billions of dollars aren't going to be appropriated to perform what is literally more than 30 specific services authorized in the Act, "plus any other." I thank you for your time and attention and look forward to the discussion.

[The prepared statement of Mr. Binstock follows:]

A NATIONAL NETWORK OF AGING RESOURCE CENTERS (ARCs): A PROPOSAL FOR THE 1991 REAUTHORIZATION OF THE OLDER AMERICANS ACT

Statement
presented by

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Senator Pryor and Mr. Solomon; I am honored to be invited to present my views at this first in a series of Congressional seminars focused on the 1991 reauthorization of the Older Americans Act (OAA).

This morning I am going to propose a new role for the Network of agencies funded through Title III of the Act -- a role as a highly visible nationwide, inter-community network of Aging Resource Centers (ARCs) to which any older persons and their families can turn to for effective help. Before spelling out what these ARCS would do, the advantages and disadvantages of the proposed role, and prerequisities for transition to effectively functioning ARCs, I would like to briefly put this proposal in context.

ACCOMPLISHMENTS OF THE TITLE III NETWORK

When the OAA was first enacted few sectors of American life were even aware of the complex societal challenges generated by population aging, and innumerable day-to-day issues confronted by older persons and their families. During the past 25 years the Title III Network has been an excellent vehicle for identifying and emphasizing such challenges and issues, for developing and exemplifying strategies to cope with them, and for providing help to millions of Americans.

The Network's accomplishments at least include: (1) continuous and dynamic identification of needs of older persons; (2) creation and exemplification of strategies, programs, and services for meeting those needs; (3) provision of tangible and intangible help to innumerable older Americans; (4) development of a nationwide infrastructure of 57 State Units on Aging (SUAs), nearly 700 Area Agencies on Aging (AAAs), and about 10,000 associated service-providing agencies, that is helping older persons; and (5) recruitment and socialization of thousands of career professionals and quasi-professionals to the field of aging. But the political environment that nourished this program is no longer with us.

TITLE III IN THE CONTEMPORARY CONTEXT OF SCARCE RESOURCES

Even as public resources have come to be perceived as scarce, and "reducing the deficit" has become a mainstay of political rhetoric, all parties interested in the Network recognize that funding sufficient to provide the more than 30 types of services named in Title III on an adequate nationwide basis would require tens of billions of dollars, and is not a realistic option.

Federal funding for the Title III Network has been limited for many years. Even the latest increase in appropriations for Fiscal Year 1990 leaves Title III far short of the $800 million level, or at less than a quarter of one percent of annual federal outlays in benefits to older persons. The need for services and programs far exceeds the resources to meet them. Although the Network draws some funds from other sources such as state and local governments, overall, in 8 of the 10 Federal regions of the country, the Network relies on Title III for about 2/3rds to 4/5ths of its funds.

As Title III funding has remained virtually level during the past decade Congressional leaders have persistently asked whether the funds appropriated for Title III (presently $720 million) might be used with greater leverage or in a substantially different fashion. Most of these queries have focused on possibilities for greater "targeting," that is, changing allocation patterns of funds or eligibility for services within the context of the Network's present mode of operation and funding level. But few targeting options have received wide political acceptance. Consequently, legislative changes in Title III thoughout the last 15 years have been minor. As the U.S. Senate Special Committee on Aging has observed regarding the OAA, "Based on testimony presented during the 1984 reauthorization, it is clear that Congress will need to go beyond the incremental changes in reforming the act, to enhance and further the goals it set for itself and the Nation back in 1965."

During the 1991 process of OAA reauthorization the Network that has evolved through over 25 years needs to be examined in the light of some very basic issues. What is the national policy underlying the continued existence of the Network? Can the funds and efforts expended on it be utilized more effectively in other ways? Can it be built upon and reshaped to play a new role that makes sense in the contemporary context?

TITLE III AND CONVENTIONAL POLICY OPTIONS

In 1991, in the wake of the Medicare Catastrophic Coverage Act's repeal, it is doubtful that Congress will be inclined to take on the political conflicts that any significant targeting initiative through the Network would be highly likely to engender.

As alternative options Congress could choose to not reauthorize the Network in 1991, or to more-or-less maintain the status quo as it has in the last several reauthorizations.

About the only advantage of eliminating the Network -- a minor annual reduction in federal spending -- would hardly be worth the political controversy entailed. The disadvantages seem clear: the cut off of services now funded through Title III; and the negative reaction that would be engendered among clients of the Network, administrators and providers in the Network, state and local public officials, and various interest groups in the field of aging.

The advantage of the status quo, as evidenced by recent reauthorizations, is that it is the path of least political resistance. The disadvantages of the status quo can be expressed primarily in terms of "opportunity costs," that is, issues concerning the opportunities that may be lost if the Network continues as it is.

THE TITLE III NETWORK IN AN AGING SOCIETY

Could the objectives of the OAA and/or the challenges of an aging American society be met better by expending Title III resources in a different fashion? What is presently distinctive about the Network that has been generated through Title III of the OAA? What is the most useful role it might play?

Most, though not all, of the services that have been developed, advocated, and provided by the Network during the past 25 years are now available through a plethora of public, private, and quasi-public agencies -- although availability is uneven, certainly, with respect to some communities. As one example, estimates are that more than 10,000 agencies and organizations in the U.S. are now providing home care services. Most services to older persons are now provided on a much larger scale through these other auspices than can be provided through the limited funds available to the Network. (The major exception is the Title III nutrition programs.)

What seems to be missing, however, for most older persons and their families is personal knowledge about such matters as: How and where do they undertake the process of getting help? From which of many agencies can they get help, and on what terms? What kinds of help will they get, and will it be appropriate and effective? Perhaps the most pressing need in our aging society is for a highly visible, distinctive site in every community -- that is part of a nationwide, inter-community network of such sites -- to which older persons and their families can turn to for beginning the process of getting help, reliably. Congress has already recognized that this is a pressing need, at least with respect to one illness, by asking its Office of Technology Assessment to provide a report on methods of locating and arranging services for persons with dementia.

The Title III Network is ideally situated to fulfill the general need for this kind of help, if it can become more visible, in a uniform fashion, nationwide. It has already evolved into an infrastructure of agencies throughout the country. If such an infrastructure did not already exist, we would probably have to build one very swiftly. On the basis of this premise, as well as on the basis of the preceding discussion of the limited alternative options, I recommend a new, legislated role for the Network.

THE PROPOSED ROLE:
A NETWORK OF AGING RESOURCE CENTERS (ARCs)

The new role I propose for the Network is to serve as a nationwide inter-community linkage of Aging Resource Centers (ARCs). The Network of ARCs would be publicized to become highly and uniformly visible, easily accessible sites in each community, for serving as one-stop sources of intake that older persons and their families can rely upon for getting effective help locally, or elsewhere in the nation.

Specific Functions

In this new role, working collaboratively with the full team of private and public agencies in the community, each ARC would:

- serve as a source of initial contact and practical information for the client(s) who does not know where to turn;
- provide emergency responses if the presenting situations -- e.g., an episode of acute illness, any nstance of physical or emotional abuse, a sudden lack of shelter -- warrant;
- with respect to cases that require complex, non-emergency responses, undertake more extended information gathering, assessments, planning, counseling and assistance, and then implement referrals;
- track progress of referrals at subsequent, pre-scheduled intervals;
- re-intervene if tracking indicates that the referral ineffective;
- regularly analyze and report on aggregate activities in order to provide administrative accountability to AoA, maintain ongoing Congressional support for the ARCs, indicate areas in which the ARCs need fine-tuning (e.g., more in-service training, greater capacity, restructuring of operations), and document important gaps in the availability of essential services and inter-agency collaboration in a particular community;
- promote, in conjunction with state and community leaders, the development of essential local services and inter-agency collaboration that ARC operations have identified as lacking -- in other words, work to fill the gaps in local services through system capacity building.

Withdrawal From Other Service Roles

These activities should become the primary or even the sole responsibilities of the Network, because this vital role probably cannot be fulfilled effectively by agencies that are involved in the provision of direct services. Although some components of the Title III Network already function in this general mode, few -- if any -- can carry out now the full spectrum of these responsibilities.

Three characteristics essential for this role -- high visibility as a community source for help; smooth, ongoing collaboration with the full range of existing community agencies; and leadership in further developing services and collaborative activities that are lacking -- are virtually impossible for an agency to achieve if it is engaged in direct competition with other local service providers, whether those competitors are non-profit, for-profit, or public. By withdrawing from the role of a service-providing and service-contracting competitor, however, Title III agencies might be able to draw on their legitimacy as officially designated components of the Network to achieve high visibility as a community intake site, collaborative working relations among the full range of existing agencies, and leadership in the development of service resources not available in the community.

Another reason why the Network would need to disengage from service provision is that substantial funds would be needed to make a transition to and function as an effective nationwide Network of ARCs. Unless Congress is willing to increase Title III funding by $300 to $400 million annually, Title III funds now used for services would need to be reallocated -- whether gradually or immediately -- in order to free up funds for the ARC role and activities.

Advantages of the Proposed Role: Why are the ARCs Different?

In addition to the general arguments presented earlier as to the need for ARCs, there are other advantages worth noting.

First, both the probability that older persons and their families will get help, and the quality of that help, will be be improved. The uncertainty of "intake" functions at present -- often through police, hospital emergency rooms, physician contacts, pharmacists, and generic social agencies -- will be reduced.

Second, issues of "means testing," "entitlements," and "moral hazards" would be avoided. Routine ARC functions, delineating the "natural history" of each case, would enable clients to receive appropriate help within the framework of existing public policies and philanthropic agencies, or through the private market.

Third, elimination of the Network's direct services would, in some communities, reduce redundancy among services now offered by a multitude of agencies.

Fourth, as ARCs deal with their clients, a solid ongoing record of gaps in services in each community would be established, providing a strong foundation -- as contrasted with "needs surveys" -- which the ARCs can use to undertake leadership to develop essential but missing resources.

Fifth, the functioning of the ARCs would build up a strong reservoir of public political support, enabling the Network of ARCs to be increasingly effective on a long-term basis, and add to the capacity of other agencies to provide help to their clients.

Disadvantages of the Proposed Role

Disadvantages of the new role would be largely transitional.

First, if the services provided or contracted for by the Network are phased out, they will not be immediately available or accessible from other sources, in the near term. But if there is need for such services, the leadership and activities of ARCs should lead to their redevelopment swiftly.

Second, a transition to the ARCs role might render obsolete, temporarily, many service-providing agencies and some personnel of the current Network, although the latter could be easily reoriented for ARC activities.

PREREQUISITES FOR TRANSITION AND EFFECTIVENESS

1991 Amendments to the OAA

This new role should be mandated by specific Congressional language; and funds now used for direct services would need to be authorized and appropriated for the operation of ARCs.

If careful "costing-out" of the activities of ARCs indicates they could be operated without reallocating the $357 million now appropriated for congregate nutrition programs, then perhaps funds for those programs should be retained, because: they have been excellent vehicles for sustaining support for the Network within Congress; as opposed to other types of programs, they are not particularly redundant, and are not likely to be developed through other auspices on a widespread basis, although a newly-formed National Meals-On-Wheels Foundation may ultimately prove to be an effective mechanism for expanding resources available for meals programs. But in the near term, at least, maintaining the nutrition programs might be an effective tradeoff to counter Network and client resistance that would be expressed regarding the new role. And congregate nutrition sites could be locations for ARCs, serving as vehicles to promote the visibility and role of the new Network.

Arrangements for Collaboration and Confederation

The role of the Network of ARCs is premised on effective collaboration with all other community agencies, not competing with them. Consequently, developing an ARC would require the formation of specific confederative arrangements with the major private and public sector agencies involved with services to older persons and their families in each community.

ARCs might also develop cooperative linkages with major corporations based in their respective communities, since the latter could play a strong role in enhancing the visibility of ARCs and might become sources of financial support for ARC operations. For instance, as corporate employers are finding that increasingly larger proportions of their employees are involved with parent care issues an effective local ARC, to which employees can be referred, may be attractive to corporate sponsors for maintaining worker productivity and morale, and promoting public relations.

Major Publicity Campaign

The effectiveness of ARCs will depend heavily upon their visibility and accessibility. Although the Network is known to a number of older Americans, it is safe to say that many millions of older persons and their families do not know that AAAs exist, do not know the names of the agencies, where they are located, or how to get in touch with them. Where the ARC is, how one gets in touch with it, and its unique role -- as a one-stop source of effective help -- will need to be common knowledge for older persons and their families who are now befuddled by a number of agencies, names, programs, and policies.

An essential transitional step toward this role will be a major publicity campaign that makes ARCs familiar and commonplace features of the American scene. In addition to the media, the auspices of state and local governments, non-profit agencies, and private corporations can be used to achieve this objective. For instance, even as telephone numbers for police, fire departments, hospitals, and poison control centers now are made prominent, so could the telephone number of the local ARC.

Structural Elaboration of the Network

Even though the Title III Network has sites throughout the nation, some communities are still lacking readily accessible locations to which older persons can turn for help. Particularly in rural areas and in selected pockets of large cities, the development of additional ARC sites will be needed, over time.

Reorientation of Network Staff and Staffing Patterns

Transition will require some changes in staffing patterns, functions, and kinds of personnel. Among the prerequisites for this aspect of transition would be intensive staff orientation sessions, using: national training modules that clearly delineate ARC roles and responsibilities, and relevant national policies and resources; and local training modules providing details on state and local policies and resources. Periodic in-service training and updates of training materials would also be needed since the terrain of policies, agencies, and resources in the public and private sectors is so rapidly changing and complex.

CONCLUDING OBSERVATIONS

The OAA has been extremely valuable over the past 25 years in helping us all to become aware of aging, the issues of aging, and creative and helpful ways to approach those issues. The Network built through Title III has provided help to millions of older Americans and models for thousands of other agencies to provide services. But prospects for substantial further development of the Network in its current mode of operation and funding level are limited. As the OAA once again undergoes the process of Congressional reauthorization in 1991, it may make sense for Title III resources to be devoted to a new role, the operation of a highly visible, and easily accessible nationwide Network of Aging Resource Centers (ARCs) to which any older person and his or her family can readily turn to locally, and/or on an inter-community basis, to get effective help in coping with the challenges of an aging society.

Mr. **Solomon**. Well, if you want some controversy, let's redo Title III; right? Very controversial.

One other piece of information to help you fill out your Larry King Show is we just finished a study for House Agriculture looking at the Food Stamp Program and reasons why people who are eligible don't participate.

One of the subgroups we looked at was the elderly. Their participation rate is very low. One of the major reasons they cite is lack of information about the program. It's not that they don't know that a food program exists. It's just that they don't know first if they're eligible, if they meet the benefit requirements, and second is they don't know how to enter into the process. I think that's just one more piece of information that adds to what you're doing already.

Dr. **Binstock**. Without a briefing book in front of me, didn't the last conference committee between the House and the Senate cut out about a $5 million outreach program on SSI and Food Stamps from the appropriation? I just thought I'd scratch something in my memory.

Mr. **Solomon**. Thank you.

What we want to do now is get into—we've had presentations and we've mostly been speaking to you from our prepared statements. What we'd like to do now is start to create the dialog that we hoped that this workshop would bring forth. What we're going to do is, we'll throw some questions here at the table ourselves. We'll also put a microphone in the center of the aisle. If you have a question, come up to the microphone and if you have an issue or a comment, this is not just for us to respond to questions. This is issues or other areas that you'd like to see addressed during reauthorization. Come to the microphone, state your name and affiliation, and then make your comment or ask your questions. Again, remember, we need your help to make this a successful seminar.

Let me start by asking a question to Dr. Stanford. Two of our major themes are equity and gap-filling. In your presentation, you discuss minority populations, diversity, and ensuring that older people in greater social and economic need receive the attention needed. This sort of relates to something that Dr. Binstock said when he talked about the need to create an information resource, a need to find out what was the term, record of gaps, and services.

It's also an issue that was raised in a paper by the Gerontological Society of America which talks about the need for better information. Can you comment Dr. Stanford and/or Dr. Binstock on whether there's really a lack of services for some target populations, whether it's an issue of gap-filling or whether there's a complete absence of services for particular populations?

Mr **Stanford**. Based on the information we have at this time, there are pockets around the country where there is a complete lack of services. More attention must be given to knowing what the gaps are and beginning to provide ways of providing services to meet those needs in ways that are appropriate for those particular populations.

I think what has happened and I think it's addressed quite often by some people at the local level and that is, that if the guidelines do not quite fit, then they really can't come up with reasonable ways to justify the expenditures to meet the needs of those particular people. I think what we need to do here is to look at what I would call "standard exceptions" so that those persons who have needs can get the needs met. It is not a matter of having some pockets in the population that really do not get services. In other instances, it's a matter of trying to finds ways of meeting the unique needs of those that we identify.

Mr. SOLOMON. Dr. Binstock, your proposal would to some extent address that because we'd know better where these gaps occur?

Dr. BINSTOCK. Well, yes, and hopefully if you had faith, that that would give you the leverage to say, "Hey, we had 423 people in this State that we couldn't get housing for in the last three months who needed it. Real people. We went and we tried. Those people are homeless now."

I think more fundamentally, if I may use this to tie in with the whole question of funding and so on, the whole notion of the network trying to provide services forestalls getting services done the right way. For example, as Rob mentioned, Medicaid has been institutional in its orientation meaning, of course, that Medicaid-eligible older people can be fully paid for in nursing homes if they qualify through their poverty, so to speak. On the other hand, Medicaid-eligible older persons can't have the sufficient range of home services that are necessary to maintain them at home because the full range necessary, in most instances, is not reimbursed by Medicaid.

Now meantime, people pushing services at the State level such as in our State, complain bitterly that even with some funding and with the most wonderful management in the world, where are they going to get the personnel to provide these home care services. I would submit to you, that you're never going to lick that problem on a piecemeal basis. Much as the proliferation of nursing homes came about through the funding of nursing homes, the proliferation of home care services at an adequate level will come about through people being eligible for reimbursement.

I would leave it at medicaid for the moment. I don't want to get into the issue of non-Medicaid long-term care because I think that's very complicated. But at least, for example, I don't think the home care gap should be filled through the Older Americans Act. I think it ought to be filled by amending Medicaid to at least give poor people a choice between home care and nursing home care. The costs are about equal.

Mr. SOLOMON. Following up on the area of information and what we know and what we don't know and also following up on the area of whether we provide direct services or whether we act as a conduit through the Older Americans Act, let me ask Dr. Hudson.

What do we know about the relative efficiency and effectiveness of direct services as opposed to service referral? What's the literature out there tell us?

Dr. HUDSON. I think there's some issues so fundamental that there's no literature I know of that gives a particularly good answer to that question. The very issue of how to measure the effectiveness of direct service is often at issue. If you provide somebody a hot meal in a congregate setting an you don't provide anything else, it may have been the greatest meal ever but if seniors can't get down the four steps to leave the congregate meal site, they're in big trouble. The issue quickly jumps from discrete services to packages of services and even there you still have larger issues around what, in fact, are the goals being maximized.

I think the question ought to be addressed at a somewhat higher level of organizational concern not unlike what Bob's been talking about. We need to find out what a given client needs and there will often be more than one service called for. Then one asks about the capacity of the system to meet those needs, and works toward creating the linkages that an ARC or some other entity might be able to make.

The question about direct services versus indirect services I think is something of a red herring. I would rephrase the question. Clearly at some point you need both. The issue is more around packaging and different ways of accomplishing that.

Mr. SOLOMON. We'll open up the microphone at the floor. At the risk of preventing a stampede to the microphone, I'll also mention that if you have other comments or if you have other issues that you'd like the committee to address, please, you can provide them in writing over the next couple of weeks to the committee.

STATEMENT OF DON EDWARDS, COMMISSION ON AGING IN ALEXANDRIA, VA

Mr. EDWARDS. My name is Don Edwards. I'm with the Commission on Aging in Alexandria. I've been working with them since about 1975. I appreciate the comments about I&R which is what the ARC is all about. It's been tried in many different places. The only place I know of that it's working is that county right above Dade down in Florida where United Way does the job. All of the social records are made available to United Way as a social worker goes out and makes a call and the county board supervisors analyze whatever the results are in terms of the trends so that they can forecast how they need to staff social agencies in the future.

As one who has worked on a Commission on Aging and has believed that the function of the Office of Aging is to be an enabler, I can only say that getting leadership for enablement depends upon giving them some resources to do it with. It's very difficult to make the health department recognize that they need to station nurses at senior centers—you call them nutrition sites, it's better for appropriations from an operating point of view in reaching people—they're senior centers where people receive benefits including nutrition—but if you want to get a nurse there on a regular basis for purposes of doing whatever nurses do, you can only persuade the health department to do it providing in some way or another the nurse is paid for.

In Alexandria, we have a very cooperative Department of Health which like every other agency at the local level doesn't have enough money to go around and consequently—well, we do have one agency. A nurse will come around once a week. But this is very difficult. We've got four different senior centers that we're trying to maintain for 100,000 people and this becomes a very hard staffing problem.

You've got to give resources in order to attract all those other things that you want to do in order to make them understand. So it seems to me we need to increase the Title III budget considerably and the network ought to begin working on the problem of how we make more funds available rather than fewer and that this is a matter of priority and whether it's better to take care of—in our State right now the key word is "prisoners." We want to get prisoners all kinds of color television and recreation programs and professors to teach them so that they get college degrees but we'll leave the homeless lay out on the street without housing.

I wonder who it is we ought to be taking care of. We've got a priority problem that we need you educators to get involved in for us.

The only other aspect of this thing which you people did not address but I wish one of you would talk about is that I understand the Administration on Aging director was nominated last November. My calendar says this is almost the end of January and as far as I know it's still laying in limbo. Meantime, we need a White House Conference because of the things you're talking about in 1991. It needs to be preceded by State conferences in 1990.

How do you propose that we get this kind of an activity moving in order that what you've told a small group can be made for a nationwide audience? Somebody's got to pry loose the appointment, get it done quickly, and then somebody else has to get ahead with the idea of getting the President off the dime so that he says yes, I will sponsor and these things are necessary if you're going to achieve anything you've talked about.

So let's talk about that kind of fundamental for a minute.

Dr. Binstock. First of all, Mr. Edwards, I'd like to apologize for not conveying effectively that what I'm proposing with the ARCs is not I and R. Let's say it's what I and R should always have been, but never has been. I think I've spelled out a lot more functions than what I and R does, and I regret not communicating it better.

I would say from my experience serving on AAA Commissions and State Commissions over many years that you are right. Certainly you need some sort of power, whether it's a material incentive or something else, to get people to cooperate. And I believe that for what I'm proposing the way you get agencies to cooperate is that they get dealt in or dealt out if you become a highly visible intake source. If they keep getting dealt out, they're not going to survive very long or they're going to shrink very badly in importance. They will have an incentive to play ball.

As for the Commissioner on Aging, I'm just guessing, but my interpretation would be the reason for the delay is that the appointment is not terribly important to make permanent or not permanent. As Dr. Hudson suggested, without getting into all the historical aspects, this position has dwindled down into being a relatively minor bureaucratic position whereas it started out with the potential to be a very important one in terms of aging, and a highly visible presence in the Federal Government.

What you're describing is so indicative of where we are now. To change things I think you would need a total reorganization of structure, and I would even push further than Dr. Hudson and say we ought to move toward a Secretary on Aging and a Department on Aging. Clearly, reporting to the Secretary, which is what happened the last time around for the Commissioner on Aging meant—as far as I could make out—that the Commissioner had less access rather than more, that she only saw the Secretary at regular staff meetings of people who report to her.

STATEMENT OF MOHAMED AL-IBRAHIM, FACULTY PHYSICIAN, UNIVERSITY OF MARYLAND, BALTIMORE

Mr. AL-IBRAHIM. My name is Mohamed Al-Ibrahim. I'm a faculty physician at the University of Maryland in Baltimore. I think Professor Binstock's idea of the ARC is very good. I hope that the name or the abbreviations don't get mixed up with AIDS-related complex which is frequently used in the medical jargon right now.

I have two comments to make, both of which I think were touched on briefly by Dr. Stanford. First of all, as far as undergraduate education, I think that's a very, very important area for support. A few years ago, we participated in a demonstration project to get senior medical students to go and learn about home care. It lasted for a year. It was very successful. Three years later, it's still ongoing. We have trouble getting people at the post-graduate level because not enough undergraduates get exposed to the issues of the older individuals in their care.

I suggest that specific dollars be identified to be spent in innovative changes in the curriculum in order to actually bring students of that level in contact with what we're trying to have them achieve later on.

My second comment relates to the urban area and the older individuals who get health care. The acute care hospital, I believe, is a tremendous place to catch individuals who are frail. They inevitably get hospitalized and they frequently get hospitalized frequently, more than any other group. I think that at that point, the information that can be conveyed to them in identifying those as a target population is very important. Through appropriate discharge planning, one can effectively match their needs in the community as opposed to having the kind of fragmentation that we all see.

I think that again, as far as target population, the use of the emergency room by the urban senior citizens is important, especially in our experience and we have some good data on that and there isn't an awful lot of literature on it but from what one can glean, other institutions and facilities have the same kind of experience. Black older women have the highest use of the emergency room and constitute one of the highest proportions of admitted patients. I think we can try to find out why this is so. Is it just economics? Is it behavior? Is it transportation? I think this is again a kind of group that we can try to identify, study, and also do something about.

Mr. SOLOMON. Before you leave the microphone, let me ask you a question. Implicit in your discussion here was that the acute care hospital or the emergency room, the direct statement was that they're a good area to identify people most in need and that you need better transition from the hospital back to the community but implicit in there is I think the statement that they're not doing that well right now.

I guess the question I bounce back to you is—I guess two questions. Underneath the current Act, what if anything can we do to improve that operation and the second is, if you had to change the Act and make it better, what kind of changes would you suggest?

Mr. **Al-Ibrahim**. Well, I'm not as versatile in the Act as the distinguished members of the panel. I do know that the limited kind of experience that I had with funding from the Office of Aging Activities has been the demonstration project that I mentioned with home care. I think demonstration projects of that kind can again identify activities such as discharge planning which do involve very much community liaison people, agencies, social work agencies.

My feeling is that in the acute hospital—first of all, it's a golden period to identify these patients.

Mr. **Solomon**. They would agree with that.

Mr. **Al-Ibrahim**. Second, there's a tremendous amount of information that's generated, both medical, social, and other and if that can be then taken to the community source of provision of care, I think we would have achieved something. I'm afraid exactly what changes in the Act. I leave it up to you.

Mr. **Solomon**. We're still open for ideas.

Dr. **Hudson**. What was the place of the State units under the ARC plan? I take it the ARCs would be largely area agencies.

Dr. **Binstock**. The place of the State unit? Central. Administering their setups in the States. For example, setting up intra-State funding formulas, seeing to it that reorientation and in-service training were carried out to keep updating on State and Federal and local eligibility policies and so on, a whole host of——

Dr. **Hudson**. Related to that function.

Dr. **Binstock**. Right, and also, playing a central role in terms of the politics of filling the gaps, the leadership question, and trying to mediate among the various areas and their needs to go in as a united team to the State legislature rather than fighting with each other, like cats and dogs.

STATEMENT OF GAIL MARTIN, NATIONAL ASSOCIATION OF MEAL PROGRAMS

Ms. **Martin**. I'm Gail Martin with the National Association of Meal Programs and we represent both congregate and home-delivered meal programs throughout the country and certainly appreciate the good comments on the nutrition program because it has been very successful. We must say the first need of course is a meal and a roof over your head and then all the other services seem to follow.

I have a couple of questions and basically I think I would like to ask how in all of these new thoughts, in putting together what is needed out there in the network—I always like Palucci's definition of management which ~~is using~~ what you have to get what you want.

How do the various pieces fit together in some of the new proposals we're hearing? For instance, home delivered meals—many of our members are private nonprofit agencies. They've been in business for 20, 25 years, long before the Government got involved. They very often are not included in information memoranda coming through the Older Americans Act, through the States to the area agency. They are not included in training programs and yet they're out there doing the job and have been for a long time.

They also do a great deal of their own fundraising, so would we in some of these new proposals ignore some of the moneys that are supplementing the Federal dollars and State dollars, case in point. Also, they do other things. I don't think we're utilizing in-home delivered meals.

Remember, they are in the household every day, every day seeing that person. Thus, some of our programs—one in particular has nine case managers on staff which is bigger than a lot of area agencies might have.

How do you fit all of these things together? They utilize United Way dollars. Would they be ignored in some of these new—with the new overview, ARC, whatever you call it? How do the pieces all fit together? I'll ask anybody.

Dr. **Binstock**. Since I was the ARCer, so to speak?

Ms. **Martin**. The ARCer.

Dr. **Binstock**. Yes, the architect. Well, I think you may be assuming some things I'm not and I'm not sure I fully understand your question. For example, what I don't fully understand should your information be in AOA memos? I'd like to hear that part but also I think the whole thrust of your question implies that all these things should somehow be coordinated.

Ms. **Martin**. Correct.

Dr. **Binstock**. I would say quite the opposite, fundamentally because despite years and years of people in the social welfare field crying for comprehensive coordination of everything, the fact is that our political system is designed to fragment everything. They've been fighting upstream and they're trying to overcome impossible forces. The very Constitution and the papers written to justify it, the Federalist Papers, make it clear that comprehensive coordinated systems is what we don't want in this country.

The second point is that what I have described is if you can picture this ARC standing tall, in as reasonably neutral and public spirited sense as we could expect from any actual entity in our world, its thrust would be to maximize the resources and coordinate by wheeling and dealing people to the appropriate places so they find somebody who's eligible for the respite program at the Menorah Park Jewish Center on Aging and they send them over there. They find somebody that's eligible for the Catholic Charities program, they send them over there. They find somebody who might not fit Title III nutrition programs but they say hey, we've got the alternative meals-on-wheels program. Let's get them over there, okay?

Why inherently this implicit notion of coordination is hanging there, I don't know, rather than free-standing utilization of what we've got.

Ms. **Martin**. All right. I think you are missing my point then. For instance, if not every town in a community or a county is covered with the home delivered meal programs and I'm focusing on that because obviously that's the group I represent, they should be part of the planning and policy beginning to say how can we open a program there. Are you going to expand your services, private, nonprofit to that area or is the county whatever group going to go in there.

How many people do you have on your waiting list—550 in the city of Buffalo for home-delivered meals. That information has to go back and forth. That's what I mean about coordination. I'm not talking about each memo. We need less memos. I agree with you on that that certainly with training. If NAMP didn't do its own training program of many of these private programs, they would be out of luck totally. So coordination is important in some areas.

Dr. **Binstock**. Right, but we are talking about the same thing if I remember correctly without going to my statement. What I talked about was developing a very clear, aggregate record of what isn't there as well as what's been done, and provide leadership and collaboration with the full range of community agencies, public, private, and nonprofit, and going to their legislatures and their local governments and philanthropic sources, and the whole sector I left out, the corporate sector.

Ms. **Martin**. A big one.

Dr. **Binstock**. Right—to fill the gaps. So I think we're right in tune.

Ms. **Martin**. Thank you.

Mr. **Solomon**. I didn't imagine that we'd hear anybody saying we have services out there that we can get without this large increase in funding and we're going to ignore them. The world of resources is too scarce for that to happen.

Ms. **Martin**. Precisely, but the methodology of incorporating them together that is obviously lacking now, the mechanism to do that is really what I was looking at.

Mr. **Solomon**. I appreciate the comment on not being in the information loop because I think that's an important thing that can be dealt with whether it's within the current structure of the Older Americans Act or whether you go to a new kind of structure, the point still remains.

STATEMENT OF DEBRA WERTHEIMER, PHYSICIAN, UNIVERSITY OF MARYLAND

Dr. **Wertheimer**. My name is Debra Wertheimer and I'm a physician at the University of Maryland as well as a medical director of a health services in a senior center in Baltimore and I'd like to make a couple of comments.

One is in response to your question to Dr. Al-Ibrahim about discharge planning and the Older Americans Act. I happen to run discharge planning on the medical services at the University which is an interesting experience for several reasons and I think that it really does tie in with what's going on with the Older Americans Act.

We have a large interdisciplinary group which has developed at the University which I think is very unique and very different from many discharge planning services at hospitals and it has attempted to do some of the things that I think need to be done for reaching older Americans who are hospitalized. Primarily though the difficulties we run into are that it's difficult to find the resources in the community. Because I happen to be a medical director at our Waxter Medical Services which is located in a part of the Commission on Aging, I know a lot of the resources in the community but that team, until we really developed it, did not have the resources and the knowledge of the services that were available to the older Americans because those people are so involved with services that they can't learn over and over again.

So one of the things I would suggest is that this information be able to be easily passed back and forth between people who are providing services and those people who have accumulated what resources are available in the communities but the other thing I think needs to be pointed out is that without the Commission on Aging certainly in Maryland and in Baltimore, many of those services would not be available. So that I don't see that there is anything to pick up if they became just an information network resource right now. That's one comment I had to make.

I think it's also important both in my position at the hospital as well as at the senior center to say that preventive health care is not being really reached and looked at with the kinds of resources that I think ought to happen for the older Americans. Many people if we looked at their functional capacities either while they're in the hospital or before they wound up in a hospital would not need the resources that need to be expended on them after the fact.

I don't see that the Older Americans Act is really achieving that kind of a goal. What we're doing now is looking for gaps and stopgap measures and not really preventing some of the functional debilities that are occurring and I think with some planning that could happen in a very reasonable way. I think things like nutritional centers which are—I agree with the first gentleman—really senior centers and provide multiple services would be an important part.

I think physicians and hospitals are another place that could look to prevent functional deficits or improve functional deficits and prevent all the things that we hate to have happen to the seniors that we're all dealing with.

The other two comments that I'd like to make are, once again, education. I think education is really abominable in terms of dealing with the older Americans and it is not only medical education although that is certainly high on my priority as a group of individuals who clearly deal with the older Americans and who are gatekeepers and do not do a good job but also all the health disciplines and I think it's also important to say that the health disciplines don't work together very well and we ought to be looking at not multidisciplinary groups but interdisciplinary groups and ability to try to have the health disciplines learn what each other do and how to work together so that we don't have duplicate services but also that services that are necessary, all the health professionals know about and can achieve.

The final thing is that there needs to be some real look at research in the elderly. There are things that can happen for the elderly that we can do again to prevent some of the disabilities that we are finding now and having to deal with. Simple things like there is research going on now where if you do weight reduction in the elderly, you can increase the functional capacity of those elderly and it looks as if that weight reduction can increase the functional capacity almost as much as you can in younger populations.

Dr. **Binstock**. Is that in the fat elderly? I mean this seriously.

Dr. **Wertheimer**. It is in both.

Dr. **Binstock**. Because in normal elderly, as far as I know, the data show that an extra 10-percent increment of weight is healthier for you and life tables have been recently revised to reflect that.

Dr. **Wertheimer**. Certainly the fat elderly, I think, are ones who have an increase in their functional capacity well above those and I guess really what I'm meaning is exercise more than weight reduction although it tends to be weight reduction exercise programs which increase the low functional capacity.

Dr. **Binstock**. Could I respond to a couple of the points?

Mr. **Solomon**. Let Rob start.

Dr. **Hudson**. To bring it back in, you've obviously posed—if we could solve the problems inherent in your question, we'd be out of here but bringing it back to the more narrow purpose here, I would suggest that some of those things—not all—but some could be done. It goes back to my question to Bob a second ago that what I've been impressed by in the context broadly read of these Older Americans Act agencies in recent years. Actions at the State level (hopefully getting to Baltimore) in Arkansas, Oregon, Wisconsin, and a few other States show in fact what these agencies are now doing what they were long ago supposed to be doing. You have strong leadership, and in Oregon you have the State aging agency that essentially is taking on home-based Medicaid functions.

In Arkansas, you in fact have a version of ARCs that's in place but indeed with a strong State-level advocacy role. So I would hope, in prevention and some other areas that you might have a serious I&R case management function at the area level. But at the State level and implicitly at the Washington level you need strong leadership in agencies that would work with State public health departments, that would work with State Medicaid directors, that would work with State rehab commissions, so that a lot can be done at the State level to inform and smooth out of the way for whatever plays out at the area level. It doesn't have to be a State agency on aging but I suspect in Maryland or a lot of other places if prevention, we're going to be the real emphasis, that there's no reason why a highly respected and well staffed State aging agency could not declare for a 2- or 3-year period prevention to be one of its very high priorities.

Dr. **Binstock**. Just on a couple of your points near the beginning, one about the information, you can't get it, et cetera, that's—I agree thoroughly and that's precisely why we need these things.

One of the prerequisites that I didn't go into is a whole thing called reorientation of network staff and staffing patterns including periodic in-service training and updates of training materials, since the terrain of policies and resources changes so quickly.

The staff should be on-line and updated, and this shouldn't be an idiosyncratic matter. It should be like a park bench in American society, to have one of these ARCs accessible.

The second point about if the services were cut off, that no one would be there to pick it up. I just have two brief things to say.

One, whenever you make a decision to do something new, there's usually a trade-off and some pain—cut off an old product, start a new line, whatever it is.

Two, the notion of "there's nobody to pick it up" doesn't hold water with me and my knowledge of history through several centuries of America. There are counties. There are cities. There are other kinds of municipalities. They pick up or create all sorts of things which were never known before to be essential public services. And people pay for them. They're willing to pay taxes for them, starting with police forces, fire forces, health services. None of those things ever existed. When they are seen, as essential, there are entities and people to pick them up.

Dr. **WERTHEIMER**. My question is that right now, certainly in Baltimore, what we're dealing with are services that are very limited at the best with many, many people who are awaiting services or who have not even—who need those services and are never going to get them.

I don't see any of those other community agencies coming through to try to pick them up and yet they're identified as essential services I think by the minority groups and others who need them.

Dr. **BINSTOCK**. I understand that. Another way to put what I'm saying is perhaps they're passing the symbolic buck. If there weren't the target to pass the buck to anymore, in the form of network services, perhaps they wouldn't pass the bucks.

Dr. **STANFORD**. Just a very brief comment in response. One of the things I think we really should focus on in the legislation is the tone that is set. The tone is as if we're responding to crisis situations all the time. When you mentioned prevention, it certainly did trigger some things in my thinking. That is, if we look at targeted populations, the situations that many find themselves in as far as health is concerned are negative. If we'd spend more time and more effort in prevention, we'd certainly save ourselves a lot of agony in the long run.

So I think we really need to focus on that particular issue. The other thing you mentioned that is very important is the approach to services from a team perspective and that rings a particular bell at this time because one of the things we're doing with our geriatric education program is trying to get medical personnel and people in the health professions, to work more comprehensively together. You mentioned the methodology. More emphasis should be on methodology in the language so that that kind of thing can happen systematically.

It just makes a lot of sense. It ties into what Dr. Binstock is talking about also.

STATEMENT OF JIM BERGMAN, EXECUTIVE DIRECTOR, HEALTHWAYS FOUNDATION OF NEW JERSEY

Mr. **BERGMAN**. My name is Jim Bergman and I'm executive director of the Healthways Foundation in New Jersey. I have spent maybe 23, 25 years in the aging field, mostly in Massachusetts so a few faces are familiar here.

First, I do want to commend the committee and the GAO for hosting this kind of session. I think that we're all used to hearings and briefings. I think that this semibrainstorming session or format may in fact be a very useful one as a way of kicking around ideas for reauthorization. I think you're to be commended on that.

Let me respond somewhat obliquely rather than directly to some of the comments of the people who have been speaking. First, it seems to me that the key issues as we look at reauthorization are leadership, targeting, focus of the Older Americans Act services on the rights and autonomy of individuals and fourth, enhancing efforts of the aging network to utilize outside resources, both State and private and it seems to me that as you were saying, it's the tone of the Act.

I think we all are not overjoyed but certainly recognize that we're not talking about a reauthorization here where we're looking at substantial amounts of new money. We're talking about level funding and we're talking about level funding for much longer than any of us are comfortable with. The question then I think is how do we tackle a reauthorization? One way is the status quo and just leave it untouched as it's been mentioned.

It seems to me that one way of addressing it is in tone and specifically coming in very forcefully and saying leadership is the key and leadership on a Federal level means very simply, putting in the blockbuster piece of the Act being, we're going to upgrade the Administration on Aging to Cabinet status. Very simple.

Follow the lead of over half of the States in this country already who have done that and shown that it works. This is no mystery. All it takes is saying it and in fact, it could be the centerpiece of the whole Act and when someone comes back later and says you haven't done very much, the answer is we haven't put a lot of money in but what we have done is say we're now going to put leadership where it belongs and let that leader be in a position to fight a budget director much more aggressively.

That then translates down into the States. Should there be incentives in the Act to encourage States, to pull States along that haven't already set up Cabinet Offices of Elder Affairs? A possibility. But at least the thrust of the Act would be leadership, high level leadership.

It's rather simple but it also works. It's not like H.L. Mencken's thing. If it's simple, neat, it's usually wrong. In this case, it's simple, neat, and it's right, and it's time.

Second point—targeting. I think Percil made a very major point on this one and that is the Act in fact does need to be targeted. I think in many ways, the social and financial need that has been within the Act the last few years makes eminent sense but on the local level, area agencies are having enormous difficulty interpreting what that means when they start putting money out. There is pressure. Take legal services. There is pressure there to pay for lawyers to do wills. Is that targeting social and economic need in most cases? There's a need there I think for guidance. Why not in the targeting go beyond saying social and economic need and give specific examples of what I would refer to as the hidden elders or really the elders that we don't want to see, that is, people in nursing homes or more importantly maybe, older people within mental institutions. Go into any mental institution these days, mentally ill or mentally retarded. It's a geriatric facility.

The gentleman from Virginia I think mentioned prisons. Go into the prisons these days. It's a geriatric prison in many respects. Take a look at the population of homeless and there are an awful lot of older people who are homeless. There are many vulnerable elders out there who could be put in that targeting category—elder abuse and neglect or protective service individuals, individuals who are at risk of guardianship, the ultimate taking of a person's rights.

Targeting can mean giving specific examples, saying yes, the person had to be socially and economically at need but beyond that, if they are in these categories, then they in fact should be targeted for Older Americans Act services and furthermore, that says that when an older person who is abused or neglected is identified by an aging network agency and finally convinces the person to ask for help, not saying to the person, you've got to get on the waiting list to get a homemaker or you've got to go on the waiting list for a meal and it's going to be a month.

Anyone who's ever done protective services knows bloody well that it's a matter of getting a person to consent to help. That is not the time to say to them you're on a waiting list. Priorities, targeting means, priority for service and saying you can jump the list. The Act I think could address that directly.

The fourth point, enhancing efforts to the aging network to get outside resources, this in a way, I think, goes to Bob's point only it comes out the other side and that is, in many respects, the Act needs to both—probably through Title IV—say, let's put some money into building stronger relationships between the public and private sectors. We've done great on lip service on this. We've done very little when it comes to real action.

Second however, I think it also means with regard to the AAAs, it means maximizing—maximizing their flexibility to be innovative and aggressive in getting both public sector money and private sector money. I think Rob's point is well taken that in many respects, it's been on a State level and an area agency level that efforts have really gone forward to try and be innovative and aggressive. It's still a bell-shaped curve but you don't want to change or reduce the flexibility of the AAAs so that you take out the best part of the bell-shaped curve, the aggressive, innovative AAAs.

I say this as somebody who was assistant secretary of the Massachusetts Department of Elder Affairs when it was first set up and it happens to have been the last State to agree to AAAs. We fought it tooth and nail, ended up in the Governor's office with Dr. Fleming throwing a pen saying, you've got to sign the damn thing, not someone who has been particularly receptive to the role of AAAs over the years but I think at this point, reducing their flexibility, cutting back on their ability to be innovative, is probably going in the wrong direction if we're trying to get more State resources or if we are trying to get them to be innovative and pulling in private sector resources.

So I think my response I think, Bob, would be, it's probably not a good idea to move in the ARC direction as much as it is to try and give them more ability to be flexible.

Thank you.

Dr. HUDSON. Let me make a couple of points. I too—I did not realize I came across as such a "stand-patter." There are all sorts of specific provisions in this legislation I would get rid of in the name of flexibility but going on for 22 minutes when you have 20 makes that difficult.

On the secretarial level, it may be simple but it also may be spurious. If you look at Oregon, you look at Wisconsin, you look at a couple of other States that are doing things, they don't have cabinet level departments. There's a case that was made back in the late 1970's that Pennsylvania was much better off when their aging unit was in the Department of Health and Human Services where it was able to tie in to a good deal of old Title XX money. Then when they split off as a separate department, all sorts of bureaucratic intrusions got into the way of their continuing to work well at the county level.

The creation of a Secretary on Aging in Washington—I think there are two sides to that. It's probably equally easy to invest a Commissioner within the Department of HHS with certain requisites, but, again, it's going to come down to leadership, to have a person who could work quite effectively within that Department and perhaps beyond it without our having to go back to a dinosauric, symbolic argument about where the Commissioner on Aging should be placed.

I think a lot of blood would be shed over something that not necessarily is going to make a difference. The historical example is that the Peace Corps under President Kennedy was five levels down in the State Department but it didn't make any difference because Kennedy liked the Peace Corps. I wouldn't equate AOA with that situation at this point but the logic holds out.

Then last, you are interested in the aging populations in mental retardation facilities, mental hospitals, prisons, a host of institutions but second, acknowledge flat funding, and third, want to increase the flexibility of area agencies to do more things. I'm not quite sure how you can have all of those simultaneously. Do you want to tell them to spend all their limited money in institutions or in analogous facilities? Do you want to tell them to do whatever they want to in their own best interest?

I don't mean to lay that on you but it's hard to maximize all those simultaneously.

Mr. BERGMAN. Let me respond real quickly to these because there are other people who would like to speak.

No. 1, I think I agree that Cabinet level status does not guarantee anything. Leadership is always going to be the key and that's the individual who is there. The difference I think is that the odds are much higher that the person has to show leadership or is going to get knocked around very vigorously within the news media if they have Cabinet level status.

Yes, there are States that haven't worked very well that way. Wisconsin is a good example of a State that has worked very effectively. Why? Good leadership. Every time. I think the question is where are you more likely to have leadership assert itself or be forced to assert itself. We all especially in this city recognize that when Cabinet secretaries don't perform, they get labeled relatively quickly as being quiet, as not doing their jobs.

It's a thing that takes its toll. It takes its toll on the President. It takes its toll on the Cabinet office. There is more likelihood of pressure being brought to bear. It also means that on a State level for example, does it always mean more money comes in? Not necessarily but more times than not it does mean more money comes into that Department when they have Cabinet level status.

Second, it also means that you've got a bully pulpit for that Cabinet secretary that you do not have if you're buried three layers down. Your can take the charge and make the charge on a specific issue as a Cabinet secretary in a way that gets visibility but doesn't cost money that you can't get when you're buried three layers down.

So I would argue as a lawyer, yes, you can argue both sides. On this one I think the argument is much stronger and yes, there would be bloodletting but maybe this is the place to let the blood.

Dr. **Hudson**. How do you explain C. Everett Koop? Koop probably could have been less as a Secretary as he did where he was.

Mr. **Bergman**. I'm not sure of that.

Dr. **Hudson**. He certainly didn't seem to be——

Mr. **Bergman**. He wasn't impeded because he was a leader. Would he have been even more effective at Cabinet status? Probably. I mean you can take it both ways but I do think it's more compelling that the higher up you are, the better off you are on this one.

Targeting issues—does that mean spreading limited resources in more directions? No. What I'm really suggesting on the targeting is, let's be more specific in the Act about who are vulnerable populations within that socially and economically deprived group. Let's give some examples in there. Let's not say you have to fund institutionalized elders or programs like that but what it says to the AAAs and the State agencies I think is here are some areas where you can start to take the initiative. You can do a legal program that focuses on the institutionalized mentally retarded and that's a way of going at that rather than doing a scatter gun approach. Pick off those areas.

I think that will be some help to AAAs who right now are still having some difficulty, I think, understanding what it means to target those groups. So, again, I think you can do it with limited resources.

Dr. **Hudson**. But you talked of the ones with leadership. They don't—I mean they're the good ones with leadership, the people you're talking about. They're doing that anyway. They say: "reduce the restrictions on me. Let me do it my way in my place and if I'm a good leader which is what you want, I'll do it. The amount of time I spend going through 307(a)(1)/3 is driving me nuts. Give me enough rope to hang myself with."

Leadership may be your answer, tricky as it is.

Mr. **Bergman**. Again, what I'm suggesting is not mandates on this one, but examples within the Act of what to do so that you—then AOA again, or at this point a Cabinet Office on Aging could take that leadership and give the examples to them.

I'm again saying, give them more flexibility in what they can do. I happen to think case management does make sense within an AAA if they want to do it. I think running an elder care program and marketing to private business may make sense. So I believe in the flexibility there and allowing them to have it. On the targeting issue, I think that one of the three or four most important things that should come out of this Act is better definition of targeting and there I think the Act needs to give more examples of the vulnerable population and it needs to focus on those socially and economically at need and minority elders within categories.

So I don't think I'm contradicting myself on this one.

Mr. **Solomon**. Thank you.

STATEMENT OF TED KAUF, UNIVERSITY OF ARIZONA

Mr. **Kauf**. My name is Ted Kauf from the University of Arizona. My compliments to you gentlemen for the effective job. I think it's right to concentrate on Title III but can I distract you for a moment to ask you in thinking about the revision of the Older Americans Act, should we do anything about the Federal Council on the Aging? Should we do anything about the White House Conference on Aging? Both of these are important parts of them.

Do you have any comments about those other divisions of the Act?

Dr. **Hudson**. I'll let Bob talk about the White House Conference.

I actually do have a comment on the Federal Council. My thought, going back to trying to make AOA at some point an analytically more able and staff office, is that I would think those very limited dollars—some $200,000 a year that go into the Federal Council—and maybe a few million more put into a policy analysis shop located somewhere an AOA with effective AOA leadership, could in fact do the kind of thing that Jim's been talking about. It would be very effective.

I'm not quite sure what the council does standing off by itself with such limited resources of its own.

Dr. **Stanford**. I don't know Ted. It seems to me that when we look at the White House Conference on Aging or the proposed White House Conference on Aging, there's some value to moving ahead. The value is that it would give us a chance to begin to look at what is going on at the local level, what's going on at the State levels and begin to put some of the activities for the last 10 years in perspective.

It gives us a chance to look at some things retrospectively. As for the conference itself, we still struggle with what some of the outcomes should be and what some of the outcomes have been. My sense is that it would do two things. One is to help us to look at not only the 1990's, but as we move toward the 21st century, what kinds of things we really need to prepare for.

So I think in terms of the importance of the White House Conference, we're really looking at the long, long range at this point in time. It's a very important pivotal point. I would just say to the leadership at this time in Washington that yes, we must move ahead with some kind of planning or give us some indication of where we need to be moving at this point in time.

How do we get that to happen, I think we have to talk in terms of advocacy and political strategy at this time, but I think it needs to move ahead.

Dr. **Hudson**. I'm told that in yesterday's budget, there's $1 million in the AOA budget for it. Now what $1 million will buy you, I'm not quite sure but apparently it's there.

STATEMENT OF SUSHIL SHARMA, GENERAL ACCOUNTING OFFICE

Mr. **Sharma**. My name is Sushil Sharma and I'm listening to all of you. I read the legislation. I was actually thinking about my days in the academia. This is a wonderful act. It's a good topic for someone's doctoral dissertation.

What this act is really saying is it's talking about an abstract. It's presented wonderful theoretical construct that is, you raise these wonderful objectives. You have a network of services and yet it lacks specifications.

Then expect AOA to come out with a written dissertation with complete answers and of course we don't get it and that's why we are here every 4 years. I have this philosophical question that I want to put in front of all the panelists and the audience and that has to do with the fact that we are talking about providing these services to an indefinite or an indeterminate number of people. We heard repeatedly here, we really don't know what the true estimate of the need is.

There's no way, I mean the way I've been listening to people, that because we don't have waiting lists, we have no way of forwarding this information back and forth, so perhaps we really don't have a true national estimate of needs.

Regardless of that, I want to ask you that in the reauthorization periods, should we talk about more specifics. Let me give you one program as an example but it's true probably for all other services and programs. Let's talk about the ombudsman program. Under the Act, each State is supposed to provide an ombudsman to elderly people in nursing homes and in the communities. However, it gives no specification with respect to how many, what kinds of backgrounds and also, you know, these ombudsmen are supposed to recruit some volunteers but yet there's very little specifics how they're supposed to do it, et cetera.

If you look at what's happening in reality, there's one ombudsman perhaps for about 30, 40 nursing homes with a population of about 50,000, 60,000 nursing of elderly. How realistically could anybody help these people? Should we when we are talking about reauthorization in the coming years start asking about, should we be specific. Let's try to figure out, can we really accomplish the objectives given this framework.

Now I do recognize there are both positive and negative things about specifications. I mean it's wonderful on the one hand that the AOA has now flexibility. They can modify and yet we really don't know what's happening out in reality. Any comments?

Dr. **Binstock**. First of all, one thought I had was that given the lack of clarity as to what makes for a good ombudsman or ombudsperson, you ought to fund a training program jointly among three universities in training ombudsmen, OK? It ought to be earmarked in the legislation.

The other thoughts I had are that it's easy enough, without legislation, to set up a bit of an accounting and reporting on what are your people achieving out there, and there's nothing to be achieved, without any reason, to ask a negative question at this point, like, what can these people really achieve?

My feeling is that they do achieve, and they probably help people in many different ways. I think they ought to have flexibility because, usually, helping, people when you're dealing with a mixture of public and private bureaucracies certainly requires ingenuity, creativity, and flexibility to cut through all sorts of colored tapes.

So I come back to saying, I think it's a good thing to focus on and maybe to enhance. Probably the starting place is to specify that there be a concerted effort to get a good reporting system on this, to see what can be accomplished.

Dr. STANFORD. Just a couple of comments. One is that it seems to me that we've come full circle each time here in terms of looking at research and training. If we talk about specifying in the Act down to the most finite points I don't think that's going to answer the questions.

We need to go back to the issue of leadership. If we provide training and support research and demonstration programs that are meaningful, people can be given general guidelines for moving ahead. I would not want to see us specify to the point where it takes away the flexibility of those who are in leadership positions or those that we train to be in leadership positions.

Dr. HUDSON. Your point is very well taken both in terms of the require/don't require and the impossibility of "doing the job" given the greatly constrained resources in the case of the nursing home ombudsman program. However, because so many of the residents of nursing homes are Medicaid-eligible, the idea arises factoring an ombudsman into the Federal Title XIX legislation. There would be all sorts of issues about getting it free of State Medicaid and welfare departments, but given that you've got an open-ended reimbursement program where literally a drop in the bucket could fund an enormously impressive ombudsman program, you could structure and fund it in a way that would be quite effective.

Also, if through State public health legislation or even Federal public health legislation, the same kind of thing could be done, it seems to me it might be better placed. I've never quite understood why the ombudsman legislation is in the Older Americans Act other than for the usual kinds of political reasons. The function I think is enormously important. I'm not sure that is where I would leave it especially in light of the funding constraints.

Mr. SOLOMON. We're approaching the end of this workshop but I'm not closing off. Right now there's something else I'd like to do.

Since this is the first of a series of workshops, what I'd like to ask the panel members to do and what I'd like you all to do in writing or at the microphone today is give some thought and perhaps address what specific areas the follow-on workshops might focus on and I'll ask each panel member within the area that they started discussing today whether it be target populations, services, or organizations to give us just some general thoughts on where our next workshop could focus where we could be more specific.

For people in the audience who would like to give suggestions to the committee, again, you're welcome to submit them in writing. You can submit them to the Special Committee on Aging, Room G-31, and the zip code is 20510.

Let me start with Percil, if you can talk about target populations, where we might next look in more detail.

Dr. **Stanford**. Just very briefly, I think the next step would be to try to ferret out more clearly what the targeted populations really are. I think one or two people in the audience have touched upon that. We tend to look at targeted populations as primarily the minority populations or those that are underserved, but there are others that must be considered. Future workshops and discussions should take a serious look at what those other populations are.

In that context, it seems to me that it would be very healthy and helpful to broaden the net, because it seems to me that once we have the mechanisms and the methodologies for pursuing ways of providing care that we need for whatever diverse populations we're concerned about, we then have a road map for providing the kind of services that we need.

In the next round, you might want to focus more specifically on not only the topic of targeting, but look at what are some of the broad examples that can be used as guidelines. One of the things that's happening now is that people are very frustrated, very uncertain about exactly what it is that they're supposed to be targeting to or targeting on in many instances.

The last thing I'd like to suggest relates back to the issue of training and research and demonstration and model projects. It is one thing to say we want to do things, but why waste a lot of time and money doing something if we don't know that it has a possibility of succeeding. Well-conceived model and demonstration projects will be helpful by giving insights into the probability of success or failure.

As far as the training and education aspects are concerned, it's a must. We must get more people trained and more people into some of the educational programs that will provide the leadership that we're talking about. Leadership just doesn't happen. If we don't get students in high school, elementary school, not to speak of college, to be involved or to be somehow enthusiastic about working in this field, we will continue to struggle to have a reasonable cadre of well-trained workers. We will not want only those people who drop out of other programs and then we say "by the way, would you like to major in gerontology or geriatrics?"

We don't want that. We want people who are enthusiastic and people who are initially involved. I realize, many of us are dropouts from other areas, and I'm not casting any negative light on any of us who have been in the field for years. We are trying to get new recruits.

Thank you very much.

Mr. **Solomon**. Thank you, Percil.

Rob.

Dr. **Hudson**. I would mention three areas. First, going back to what I was talking about, given the enormous diversity that exists within the so-called network, a workshop that in part would focus on somehow finding out how great is the diversity—where are the States, where are the area agencies, what are the variations by whatever dimension one might want to use—would be useful.

What I'm interested in is learning more about maybe a dozen States that appear to be doing very serious work in home and community-based care actively involved with Medicaid, actively involved with other public funding streams, increasingly talking to private insurance companies. Is that working? Is that an appropriate role? If it's an appropriate role, should it be a mandated role, a debate getting us back to some of the questions that have come up here.

Just because it's a good place, is it going to be good every place? Is it workable every place, and what is "it"? So I would make that as my first point.

Related to that and to the case management and the ARC's notion indirectly is as the network moves by choice or by necessity toward the world of community-based long-term care, the issues that both the case management function and ARC's raises are several. Can case management effectively be done by itself? Can a freestanding, relatively freestanding case agency lacking other resources, other services, other ties to the political and service community pull it off? Will it have the wherewithal to have anybody pay any attention to it if all it's doing is referring people.

There's also the so-called positive function of redundancy that public administration people talk about. I don't think case management should be housed in only one place geographically and I'm not suggesting that Bob or anybody else has said that. But in fact, if case management is done badly in the greater Stillwater area by a case management agency, what kind of appeal mechanisms does a family or an older person have? Second, there are so many so-called case management or would-be case management agencies out there, the possibility of imposing or developing a relatively homogenous national system might be difficult to pull off.

My third point is again quite different, but it is one that I'm interested in. I would like to see a workshop focus on issues around revitalizing the Administration on Aging and some of the related issues—Cabinet Secretary, Assistant Secretary for Aging, etc. Right now there is an Acting Commissioner who apparently has overcome some of the problems of the last few years, has decent relationships with people elsewhere in OHDS and within the Secretary's immediate office, but nonetheless is still reporting for a whole series of very important functions through OHDS. If that could be cleared up to the reasonable satisfaction of a lot of parties, I think we might be able to get part of the way to where most people in the room probably want to go.

Thank you.

Mr. **Solomon**. Thanks.

Bob.

Dr. **Binstock**. I do think a workshop with more extensive aspects of targeting discussed would be useful. Targeting is not a technical problem obviously. It's a political problem, both nationally and at the State level.

I've been involved in several States where there have been what you might call squabbles over the intrastate funding formula, squabbles ranging from U.S. District Court to more subdued.

I think a useful focus of the workshop would be to follow up on the theme that Percil stated at the outset when we all came in. He suggested the possibility of standardized intrastate funding formulas. I would just adapt that slightly in terms of a focus by suggesting that maybe there ought to be a workshop focused on whether there are some areas in which targeting could be standardized more than others, and why.

The last time I sat through a hearing in this room was with Senator Grassley, a 1984 hearing on targeting. I testified to show that technically you could target any one of 30 ways, but the issues were always political. Then they had a panel representing the black aged, the Hispanic aged, the Asian Pacific aged, the native American aged and then one representative of the Leadership Council of Organizations on Aging. By the time they all got done saying who ought to be targeted among older Americans in the country, I think there were about two white men left who weren't targeted. This approach just undermines the whole notion of targeting, which is, allocating with focus to some persons and not others for specific reasons.

So I think one workshop should come to grips with the fact that while all of us deserve to be targeted in one sense or another, are there some priorities and can they and should they be standardized?

A second one is on this question of leadership, that's certainly a sensible subject. It's bound to come up again anyway. Rob referred to it as a dinosaur. This is one that probably will never become extinct. The only point I would add into the discussion so far is that I think if there is such a discussion, it ought to include specific attention to the notion of a changed portfolio. In other words, not just taking the same person and responsibilities and jacking them up to put a "Bigelow on the floor" or something.

There ought to be some specification. Does this person try to mediate between the aged and the children, to overdraw it in an artificial way? Is this person responsible for doing something vis-a-vis HCFA and SSA and those sorts of matters?

The other point I would make is it ought to discuss issues of recruitment potential in a realistic way. With great respect for all the people who have been Commissioner on Aging in recent years, if you're going to do something like this, you've got to do it with confidence that you're going to be able to recruit somebody who's known to the American people in some way. Otherwise, I don't think all these "speak out" allusions that have been made are going to come so easily. They can be earned but it's not so easy, and I think charismatic leadership is one of the advantages of these elevations.

Finally, I disagree naturally with those who disagree with my proposal, and their counterpoints.

Specifically, I would recommend a workshop to examine my proposal seriously. Ask people at AOA to cost out what it would take to adequately publicize a uniformly visible network, with the same logo—to do it in a sufficient enough way so it would be as familiar as a 911 number. Similarly, they could mock up some assumptions regarding the various transitional things I've outlined, that is to say: how long would it take to reorient personnel, retrain, get in-service training modules developed so that people are up-to-date all the time, and get a system for determining who's eligible for Medicaid in your State, what does Medicaid cover in your State, who's eligible for Medicare, what are they covering, what are the sectarian charities, et cetera, et cetera? These functions could be costed out either on a phased-in basis or in a year, or both. Could it be done for much less than I think, or would it take trading off the money for services, irrespective of the competition issue on the service?

Mr. SOLOMON. I'll give you a costing out example at lunchtime based on food stamps.

I do want to take the time right now to thank the panel members. I think they've made just a wonderful presentation. I think they've brought up the issues that we really have to address. Not just my thanks but I extend the thanks of Senator Pryor to Dr. Stanford, Dr. Hudson, and Dr. Binstock. Also, give my appreciation to the participants and others in the audience. Again, if you have ideas, please write us and let us know. When you mail them to the committee, mail them to Anna Kindermann so we end up with all the letters in one place and I thank you all for attending today.

[Whereupon, at 12:15 p.m., the workshop adjourned.]

APPENDIX

Item 1

Older Americans Act Information Sheet

The Older Americans Act (OAA) was enacted in 1965 and has been reauthorized on ten occasions, most recently in 1987. The Act serves to improve the lives of all older Americans in a variety of areas including income, health, nutrition, employment, and long-term care, among others.

The Act establishes an Administration on Aging (AoA), within the Department of Health and Human Services, to administer the majority of the OAA programs and to act as the chief Federal agency advocate for the elderly. The AoA oversees a network of state and area agencies on aging. The state and area agencies on aging maintain responsibility for funding, coordinating and managing a broad array of service programs and other initiatives for the elderly. In addition to priority areas specified in the Act, local services are supported in response to the needs of individual communities. The OAA also establishes a Federal Council on Aging to advise the President and Congress regarding the needs of the elderly.

State units on aging (SUAs) receive federal funds for implementation of state plans on aging which the AoA has approved. Area agencies on aging (AAAs) then develop and fund services based upon state approved area plans on aging. Primarily through subgrants and contracts with local service providers, AAAs seek to meet the needs of the elderly populations within their jurisdictions.

Today, there is an "aging network" which includes an aging unit in each state, approximately 670 area agencies on aging, and more than 25,000 local service providers. In addition, the OAA has been the vehicle for the education and training of thousands in the field of aging.

The OAA is scheduled for reauthorization in 1991. In order to identify key issues that may merit close examination as part of the reauthorization process, the Senate Special Committee on Aging, in collaboration with the U.S. General Accounting Office, is sponsoring a series of seminars in 1990. By obtaining information and opinions from experts in academia, government, advocacy organizations, social services agencies, and other sectors, the key issues for consideration will be identified.

In addition, it is expected that legislative changes that may be necessary or desirable as part of the reauthorization process will be suggested.

The initial seminar will focus general attention on the context of the OAA and identify important issues for discussion at the first and subsequent seminars. In particular the first seminar will address three broad areas: First, target populations - who receives the services provided by OAA and who is in the greatest need for these services; second, services - the mix of services offered under the act; and third, organizations - the agencies at national, state and local levels which are involved in the administration and implementation of the act's objectives.

Four themes will be addressed in the initial seminar: First, advocacy - whether agencies and individuals mandated to serve as advocates effectively provide such advocacy services; second, efficiency and effectiveness - whether services are provided in an efficient, appropriate and cost-effective manner; third, gap filling - whether the provision of information or services that are not offered by other programs and institutions is adequate; and fourth, equity - whether the persons who have the greatest need are served. Future seminars will examine particular issues and programs within the rubric of the OAA.

At the initial seminar, James H. Solomon, Senior Assistant Director, Program Evaluation and Methodology Division, U.S. General Accounting Office, will serve as the moderator for the discussion. Dr. Percil Stanford, Professor, Center of Aging, University of California at San Diego, will address the issue of target populations. Dr. Robert Hudson, Professor, School of Social Work, Boston University, will deal with the issue of service delivery. Dr. Robert Binstock, Henry R. Luce Professor of Aging, Health, and Society, Case Western Reserve University, will discuss the functions provided by and coordination among different organizations responsible for implementing the act. Full and open audience discussion will follow presentations by this panel of experts.

January 31, 1990

Item 2

OLDER AMERICANS ACT AUTHORIZATION LEVELS AND APPROPRIATIONS

FISCAL YEARS 1988-91

AUTHORIZATION LEVELS
FY88-91 **[in thousands of dollars]**

Act Title and Services	1988	1989	1990	1991
Title II				
Federal Council on the Aging	$210	$221	$232	$243
Title III				
Grants for State and community programs on aging:				
Supportive services and centers	379,575	398,554	418,481	439,406
Nutrition services	645,130	684,837	727,778	773,017
Congregate	(414,750)	(435,488)	(457,262)	(480,125)
Home Delivered	(79,380)	(83,349)	(87,516)	(91,892)
USDA Commodities	[1](151,000)	[1](166,000)	[1](183,000)	[1](201,000)
In-home services for frail elderly	25,000	26,250	27,563	28,941
Assistance for special needs	[3]25,000	[3]25,000	([3]—[4])	([3]—[4])
Health education and promotion	[3]5,000	([3]—[4])	([3]—[4])	([3]—[4])
Elder abuse prevention	[3]5,000	([3]—[4])	([3]—[4])	([3]—[4])
Long-term care ombudsman	[3]20,000	([3]—[4])	([3]—[4])	([3]—[4])
Outreach for SSI, Medicaid and food stamps	(-[2])	[3]10,000	[3]10,000	([4])
Title IV				
Training, research and discretionary projects and programs	32,790	34,619	36,349	38,167
Home care demonstration projects	(-[2])	[3]2,000	[3]2,000	(-[2])
Ombudsman and advocacy demonstration projects	(-[2])	[3]1,000	......	(-[2])
Title V				
Community service employment for older Americans	386,715	406,051	426,353	447,671
Title VI				
Grants for Native Americans	[5]13,400	[5]16,265	[5]19,133	[5]22,105
Part A - Indian Program	(12,100)	(14,900)	(17,700)	(20,600)
Part B - Native Hawaiin Program	(1,300)	(1.365)	(1,433)	(1,505)
Title VII				
Older Americans personal health education and training program	(-[6])	(-[6])	(-[6])	(-[6])
Total	**[7]1,538,000**	**[7]1,604,797**	**[7]1,667,889**	**[7]1,749,550**

[1] Public Law 100-175 requires the Secretary of Agriculture to main a reimbursement level of 56.76 cents per meal for fiscal year 1986-91.

[2] Not authorized.

[3] The law requires that total appropriations for programs funded in fiscal year 1987 increase by at least 5 percent over the previous year before appropriations for these new authorizations are made.

[4] Such sums as may be necessary.

[5] The law creates a separate Part B for funds for a Native Hawaiian program. As shown in the table, the law authorizes specific amounts for Part A, the Indian Program, and for Part B. The law further specifies that Part B receive funding only if the total appropriations for title VI exceed the fiscal year 1987 funding level ($7.5 million). Part B will receive the first $250,000 of any appropriations exceeding the fiscal year 1987 level, and half of any increase above the first $250,00 up to the authorized amount.

[6] This title is repealed.

[7] Plus such sums as may be necessary for certain programs.

APPROPRIATIONS
FY88-90 **[in thousands of dollars]**

Act Title and Services	1988	1989	1990 (post sequestration)
Title II			
Federal Council on the Aging	$191	$188	$186
Title III			
Grants for State and community programs on aging:			
Supportive services and centers	268,072	274,352	271,987
Nutrition services	560,611	576,507	574,387
Congregate	(344,664)	(356,668)	(351,924)
Home Delivered	(75,635)	(78,546)	(78,981)
USDA Commodities	(140,312)	(141,293)	(143,482)
In-home services for frail elderly	4,787	4,834	5,756
Assistance for special needs	none	none	none
Health education and promotion	none	none	none
Elder abuse prevention	none	none	none
Long-term care ombudsman	957	988	974
Outreach for SSI, Medicaid and food stamps	none	none	none
Title IV			
Training, research and discretionary projects and programs	23,935	22,173	25,332
Home care demonstration projects	(—)	none	— —
Ombudsman and advocacy demonstration projects	(—)	none	— —
Title V			
Community service employment for older Americans	331,260	343,824	357,013
Title VI			
Grants for Native Americans	7,181	10,710	12,541
Part A - Indian Program	— —	— —	— —
Part B - Native Hawaiin Program	— —	— —	— —
Title VII			
Older Americans personal health education and training program	(—)	(—)	— —
Total	**$1,196,994**	**$1,233,576**	**$1,248,176**

Item 3

GAO Provisions of OAA

Title I	Declaration of Objectives; Definitions
Title II	Administration on Aging
Title III	Grants for State and Community Programs on Aging
Part A	General Provisions
Part B	Supportive Services and Senior Centers
Part C	Nutrition Service
Part D	In-Home Services for Frail Older Individuals
Part E	Additional Assistance for Special Needs of Older Individuals
Part F	Prevention of Abuse, Neglect, and Exploitation of Older Individuals

GAO Provisions of OAA (Cont.)

Title IV	Training, Research, and Discretionary Projects and Programs
Title V	Community Services Employment for Older Americans
Title VI	Grants for Native Americans

GAO The Unifying Themes

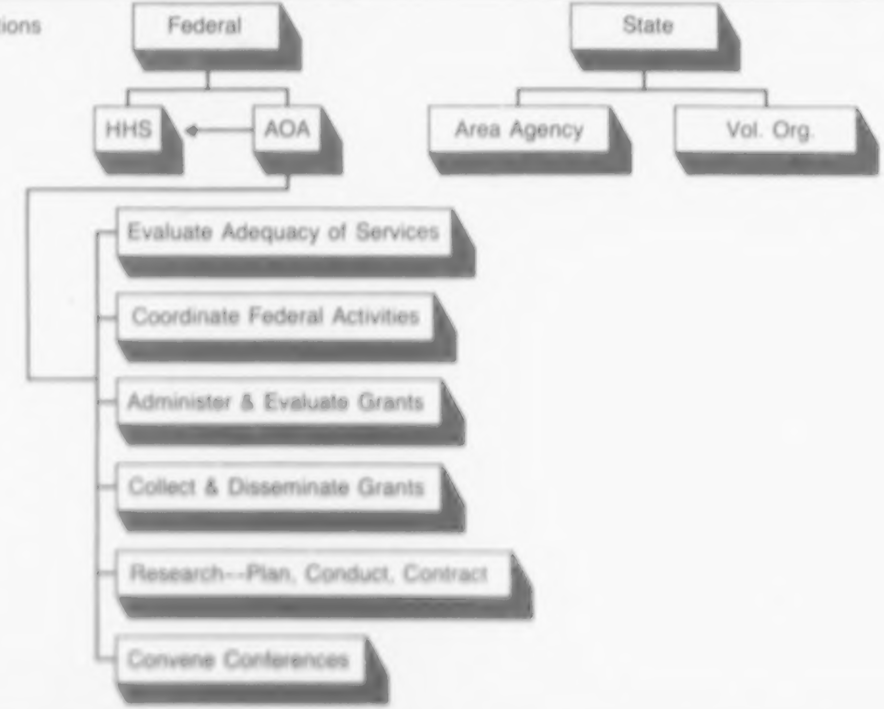
1. **Advocacy**--that is, whether the agencies and individuals mandate to serve as advocates are effectively providing such services.
2. **Efficiency and effectiveness**--that is, measuring whether services are being provided in an efficient, appropriate and cost-effective manner.
3. **Gap filling**--that is, providing information or services that are not being offered by other programs and institutions.
4. **Equity**--that is, serving the persons who have the greatest need.

GAO Objectives of OAA

1. An adequate income in retirement.
2. The best possible physical and mental health.
3. Obtaining and maintaining suitable housing.
4. Full restorative services.
5. Opportunity for employment.
6. Retirement in health, honor, dignity.
7. Participation in and contribution to meaningful activity.
8. Efficient community services.
9. Immediate benefit from proven research knowledge.
10. Freedom, independence, and the free exercise of individual initiative in planning and managing their own lives.

GAO Organizations

Organizations



Federal

HHS

AOA

Evaluate Adequacy of Services

Coordinate Federal Activities

Administer & Evaluate Grants

Collect & Disseminate Grants

Research--Plan, Conduct, Contract

Convene Conferences

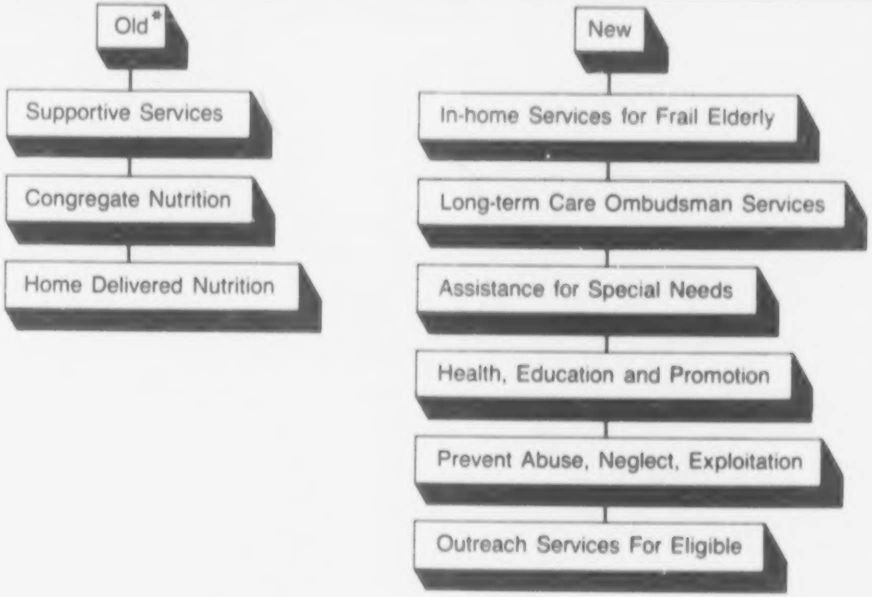
State

Area Agency

Vol. Org.

GAO Services

Services



Old*

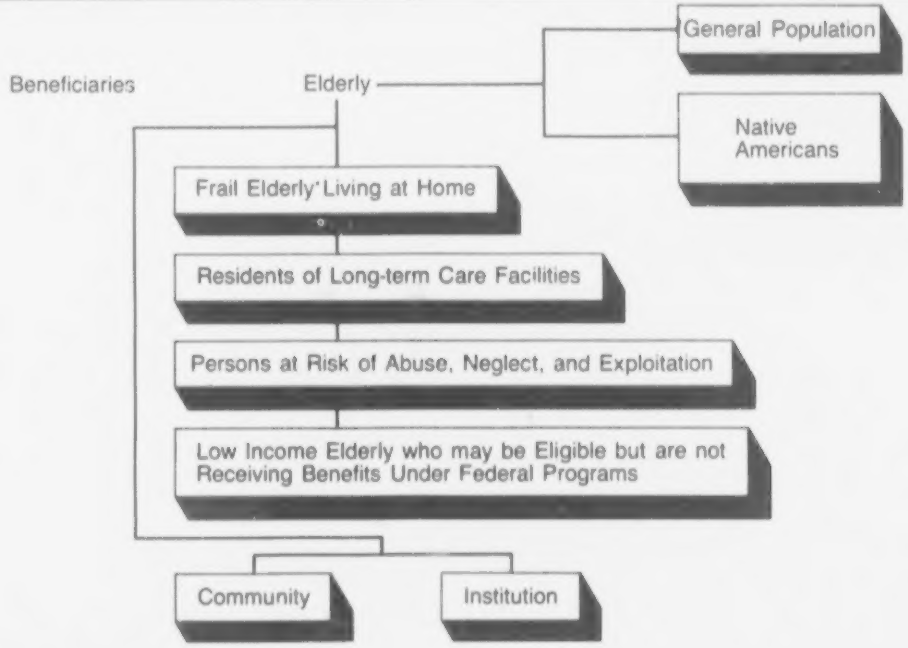
- Supportive Services
- Congregate Nutrition
- Home Delivered Nutrition

New

- In-home Services for Frail Elderly
- Long-term Care Ombudsman Services
- Assistance for Special Needs
- Health, Education and Promotion
- Prevent Abuse, Neglect, Exploitation
- Outreach Services For Eligible

*Prior to 1987

GAO Target Population



Beneficiaries

Elderly

General Population

Native Americans

Frail Elderly Living at Home

Residents of Long-term Care Facilities

Persons at Risk of Abuse, Neglect, and Exploitation

Low Income Elderly who may be Eligible but are not Receiving Benefits Under Federal Programs

Community

Institution

Item 4

Cost-based and competitive political pressures are now emerging which may threaten both the traditional political resources of the aging and the future expansion and liberalization of old age policy benefits. For reasons discussed, the most disadvantaged members of the older population — the old-old, the minority old, and widows — may become the principal victims of these pressures. Public agencies serving the elderly may also be confronted by new and more intense demands.

The "Graying" of the Federal Budget and its Consequences for Old-age Policy[1]

Robert B. Hudson, PhD[2]

The aging, long a favored social-welfare constituency in the United States, are in the early stages of being confronted with a series of obstacles which may put their favored status — and its concomitant material and symbolic benefits — in jeopardy. Rapidly rising public policy costs for meeting the needs of an aging population, a nascent but growing reassessment of policy benefits directed toward the elderly, and competitive pressures from other social-welfare constituencies are now threatening two of the aging's longstanding political resources — their singular legitimacy as a policy constituency and their political utility to other actors in the policy process.

These developments hold the clear potential for fundamentally altering old-age politics and policy. The widespread public sympathy and narrower political calculations which have been featured in the passage of many old-age policy enactments will increasingly give way to competitive and cost-based pressures, the effect being to produce a more inclusive and zero-sum politics of aging.

Three likely outcomes can be expected to result from these shifts. Major new policy initiatives or appropriations beyond those provided for under existing legislation will meet with new and perhaps overwhelming resistance. Demographic trends and existing statutory provisions already require that public expenditures for the aged will increase dramatically, and it is these increases which may in large part preclude additional enactments. For those subgroups of the aging population having special needs and not having benefitted proportionally from existing policies — the "old-old," minorities, and women — these pressures may have particularly deleterious consequences.

More critical appraisal of aging policy may also place agencies serving the elderly under new and harder scrutiny. The existence and operations of these agencies have served a number of political agendas as well as serving the elderly, and these other agendas are changing. As the aging come to be viewed increasingly as a political *problem* and less as a source of political *opportunity*, the role and utility of these agencies will be assessed more in terms of problem resolution than problem recognition.

Finally, these changes in the political environment will pose new challenges to the aging and to groups organized on their behalf. The political influence of aging interest groups will be put to a new and sterner test. The outcome will be of central interest to potential beneficiaries of new policies and, to a lesser extent, to those who have engaged in the professional debate focused on the extent of the political power of the aging and their organizations.

The following pages examine the ways in which the political factors influencing aging policy are changing, some of the reasons behind these changes, and the consequences they may have for the aging and the policies, groups, and agencies which serve them. The consequences cannot be predicted with certainty, but to the extent that perceptions and realities in the larger environment evolve as anticipated, consequences on the order of those suggested here can be expected.

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[1] The author's work is supported by a Research Career Development Award (5-K04-AG00005) from NIA, NIH.

[2] Assistant Professor of Politics and Social Welfare, Florence Heller Graduate School, Brandeis Univ., Waltham, MA 02154. The author wishes to thank James Schulz and Alan Sager for their very helpful comments on an earlier draft of this article.

Past Policies and Traditional Resources

Past policy enactments for the aging have been of two kinds: "breakthrough" and "constituency-building." Breakthrough policies consist of those legislative initiatives that have first involved the federal government in providing or guaranteeing fundamental social-policy benefits. Constituency-building policies are those that recognize and provide sustenance to related interests organized around common client, problem, or geographical concerns. The aging have contributed to, and benefitted from, breakthrough activities in income maintenance and health care and have been able to create "policy space" for themselves and their allies in a cluster of social-services policies.

Critical to these legislative successes have been the aging's political legitimacy and their political utility. Legitimacy is perhaps the most effective of political resources because it connotes the belief that something or someone should be supported. Legitimacy may also obviate the need for power because, where pervasive, its presence precludes the necessity of overcoming resistance or opposition. This is why legitimate governments do not need to post policemen on every corner and — at a more modest level — in large part why the aging have secured major public-policy benefits without overt demonstrations of political muscle.

Political utility is a more proximate and instrumental concept and one that frequently builds on legitimacy. Knowing that a given group or proposal is viewed positively, other actors will seize on it in order to pursue agendas of their own. Congressmen have furthered careers by intoning the virtues of states' rights, the family farm, the "American canal in Panama," and, one may add, the policy needs of older Americans. As the following discussion will suggest, Congressmen are not the only actors who engage in this practice. In the case of aging policy, actors with a variety of agendas have helped themselves and their interests while helping the aging as well.

The aging and policy breakthroughs. — The legitimacy and utility of the aging have led to their being both the principal beneficiaries and most functional constituency in the legislative struggles leading to the federal government's involvement in economic security, health-care financing, and guaranteeing minimum income. The objective needs of the elderly — a major factor contributing to their legitimacy — was beyond question and widely perceived at the time of each of the relevant enactments. Old Age Assistance and Old Age Insurance were enacted at a time when only an estimated 10% of the older population had any form of pension protection whatsoever; Medicare coverage was directed toward an older population whose hospital costs were twice as high and whose hospital stays were twice as long as the rest of the population; and Supplemental Security Income (SSI) payments provided a modicum of adequacy and equity to impoverished older persons whose benefits (per recipient) were as low as $38 and $47 in some states as recently as 1973. While statistics such as these were important in documenting the income and health needs of older persons, they served primarily to confirm what most persons already knew or suspected.

A more fundamental influence was the widely held belief that most older persons were impoverished or ill for reasons which were no fault of their own. Few would have disagreed with Franklin Roosevelt's statement, made while Governor of New York, that:

> Poverty in old age should not be regarded either as a disgrace or necessarily as a result of lack of thrift or energy. Usually it is a mere by-product of modern industrial life. . . . No greater tragedy exists in modern civilization than the aged, worn-out worker who after a life of ceaseless effort and useful productivity must look forward for his declining years to a poorhouse (Roosevelt, 1938).

Public support for the aged in the Medicare case had similar origins; the aged "were one of the few population groupings about whom one could not say the members should take care of their financial-medical problems by earning and saving more money" (Marmor, 1970). The relative lack of controversy around the idea of providing a minimum income to the aged, blind, and disabled allowed for the enactment of SSI whereas the broader Family Assistance Plan went down to defeat. Writing about the Family Assistance Plan (FAP) controversy, Moynihan (1973) notes simply that "from the earliest discussions it had always been assumed that any welfare-reform proposal would increase benefit levels and establish national minimum standards in the 'adult' categories."

The unquestioned needs of the older population and widespread sympathy towards them found in each of these instances provided what can be termed a "permissive consensus." For that consensus to be acted upon, however, required the involvement of some set of more proximate actors, and in each case that involvement took place. But the agendas these other actors pursued were broader than just meeting the particular needs of older persons. While the proponents in each of these episodes had genuine interest in remedying the problems besetting older persons, different concerns which they addended to that of helping the aging may have been of equal or greater importance. Put simply, the needs of and sympathy for older persons were useful to others; older persons were of instrumental value as well as being valued in their own right.

The principal actors in each of these major legislative cases hoped that by concentrating on the elderly or by attaching their proposals to the elderly they could establish a broader principle or assure yet more extended coverage. Roosevelt postponed for a year submitting his old-age assistance legislation until proposals to insure unemployed workers and establish a contributory old-age insurance system could be readied. His reasoning was that the OAA legislation would pass easily and that the others might well go down to defeat if not attached to that popular proposal (Altmeyer, 1968). National health insurance proponents, having witnessed the defeat of Truman's comprehensive health package, focused their subsequent efforts exclusively, not only on the elderly in general but on Social Security beneficiaries in particular, successfully taking advantage of both the group and the policy (Marmor, 1970). The inclusion of the adult categories into the FAP proposal clearly served to legitimize the broader proposal, and as it turned out, the legislation eventually enacted covered only these categories. The aging have reaped great benefits from these policies not only because they are seen as legitimate and deserving recipients but because executive branch leadership and those favoring an expanded social policy role for the national government have seen it in their interests to have such policies in place.

In the process leading to enactment of these policies, organized old-age interests appear to have been of only conditional or minimal importance. Only with Medicare, where the testaments of older persons and the lobbying activities of the National Council of Senior Citizens were prominently featured, does a conventional "pressure politics" model seem at all applicable. In the case of Old Age Assistance, the Townsend Movement lent a sense of urgency but emerged relatively late in the process and well beyond the critical policy-making circle. SSI was designed in a setting almost totally apart from organized social-welfare concerns, a fact indirectly attested to by the legislation's being mentioned only twice in passing in Henry Pratt's recent book-length discussion of "the gray lobby" (1976). Other factors were clearly at work.

The aging and constituency-building. — In addition to these three major enactments, a number of smaller programs have been enacted on behalf of the elderly and numerous other policy constituencies in recent years. While containing needed in-kind benefits for the target populations, these "distributive" policies (Lowi, 1964) are more notable for the political benefits which accrue to the more central figures involved in the enactment process. Policies of this kind and the political relationships which foster them have been widely discussed under a variety of colorful rubrics: "subgovernments" (Cater, 1964); "interest group liberalism" (Binstock, 1972; Lowi, 1969); "self-regulatory politics" (Salisbury, 1968); "the social pork barrel" (Stockman, 1975); "cozy triangles" (Davidson, 1977).

The popularity of these distributive policies and their political utility to different actors are not difficult to see. They *optimize political credit* by lending recognition to particular constituencies and by involving administrators who both consume and disburse appropriated funds. By legislating such programs, elected officials appear responsible in meeting perceived public needs while relieving pressures being generated by organized constituency interests. These programs also animate public bureaucracies by providing them with specific policy responsibilities and often provide a major role to organized interests in the program's implementation.

At the same time, distributive policies *minimize political costs* by entailing monetary expenditures which are only modest when weighed against the problem in question and by defining the role of program implementors as that of distributing funds rather than regulating behaviors. The hallmark of these programs is that the actual costs of each one (as contrasted with the sum of the costs of all of them) are too diffused to be perceived by the taxpayers who ultimately foot the bill. Implementation of these programs is characterized by disbursement of funds through vertical networks of corresponding agencies at different levels of government. This, in turn, means that the dangers of infringing on the prerogatives of related, but operationally separate, programs can be minimized if not avoided altogether.

The legitimacy, utility, and presumed electoral strength of the elderly have made them frequent beneficiaries of distributive policy. Recognition of the policy legitimacy of the aging and the political credit it brings is an important factor in social service, housing, home care, nutrition, senior center, and training programs which have been enacted for the elderly and is perhaps the principal purpose served by the conferences, committees, and councils on aging found at all levels of government. As has been forcefully argued elsewhere (Binstock, 1972), however, the programs have served as well to finance the work of large numbers of professionals, providers, and advocates. It is these groups, more than the elderly themselves, that have been the motivating force behind these programs. As with all in-kind programs, it is these groups which consume the actual appropriations while the formally targeted population receives what those appropriations happen to buy.

On the cost side, these distributive policies have raised relatively few problems because the elderly — unlike business, labor, or unwed mothers — have engendered no natural opposition and because the costs of these programs are minimal relative to what might be done. The most telling indictment of distributive/in-kind programs generally lies in their legislative language invariably enumerating a wide range of problems to be remedied while, at the same time, the relatively meager appropriations make for spotty geographical and functional coverage and render the notion of "entitlement" near myth. The monumental backlogs of older persons desiring services under Titles III and VII of the Older Americans Act and Title XX of the Social Security Act provide clear evidence of the inequities inherent in these in-kind programs.

The purpose of the foregoing discussion has been to suggest some of the political reasons responsible for the different policy benefits the aging as a population have come to enjoy. There are trends now emerging, however, that may lessen the political legitimacy and utility of the aging and that may place severe pressures on both new initiatives and existing policies.

Emerging Political Pressures

Three discernible sets of factors are going to make further major initiatives for the elderly much more difficult to bring about and are going to place under harder scrutiny the programmatic and political utility of the in-kind programs serving the elderly. Growing absolute and relative cost burdens for meeting the needs of the older population, increasing debate over the actual distribution and intensity of older persons' needs, and sharpening competition for limited discretionary social-welfare dollars are likely to erode traditional sources of support for the aging while yielding new competitive and cost-based pressures. These factors hold the potential of bringing basic changes to the old-age policy universe.

Most of the comments and arguments in the following sections are made with regard to the aggregate older population. The principal theme of this discussion is that benefits targeted on the aging are now beginning to generate major competitive and cost pressures. What this does not say or intend is (a) that these benefits, as expensive as they are becoming, are necessarily adequate or (b) that all older persons have shared in the policy gains which have been made by the older population in general. No one could live decently on the minimum income benefits currently guaranteed through SSI. Publicly-supported health benefits for older persons are limited in terms of the costs which are covered and/or the persons who are eligible. The lack of an entitlement feature in many of the in-kind programs denies services to eligible persons for no reason other than they arrived after the money ran out. Clearly, by even a modest standard of absolute need, current old-age policies can be deemed inadequate.

As the following discussion will suggest, however, older persons have done *relatively* well in the arena of public policy as contrasted with other population groupings whose aggregate needs can be argued to be equally pressing. It is this growing sense of relative deprivation on the part of other groups coupled with the monetary costs of old-age policies which form the core of the present discussion.

The conclusions to be drawn concerning older persons and public policy are that those older persons whose needs are the greatest may suffer disproportionately from these new external pressures and that these new pressures may come to bear, as well, on agencies serving older persons.

A final introductory note centers on the question of inflation and how real are the monetary increases discussed below. In the area of cash transfers, benefit increases have, for the most part, more than kept pace with inflation. In the area of health care, however, much of the reported increases in expenditures are the result of medical inflation rather than expansion or liberalization of benefits. Thus, despite massive increases in Medicare and Medicaid costs, older persons today have higher out-of-pocket medical expenses than they did 10 years ago. It is essential that facts such as this be made known and be appreciated in order that emerging political pressures do not deny needed relief to that large number of older persons who continue to remain very much "at risk."

Cost pressures. — Rapidly rising budgetary charges for existing policies targeted on older persons are the principal source of public and official pressures on old-age policies. Cash payments under the Old Age and Survivors Insurance portion of Social Security doubled between 1970 ($26.3 billion) and 1975 ($54.8 billion), and costs for this program are budgeted at $87.2 billion for FY 1979, with an anticipated rise to over $120 billion by 1983 (U. S. Office of Management and Budget, 1978a; U. S. Social Security Administration, 1976). The rise in the number of older persons by eight million over the next 25 years, the increasing percentage of them who will have Social Security coverage, and the declining proportion of working-age to old-age populations will all further exacerbate these pressures.

While many consider these costs to be qualitatively different from other portions of the federal budget because of their separate funding base and their earmarked purpose, Social Security is a "pay-as-you-go" rather than a true annuity system. Current contributions are paid out to current beneficiaries rather than being invested and set aside for the individual contributor. This feature has been made especially visible by the recent $227 billion Social Security tax package and the yet more recent attempts by Congress to roll it back. Taxes are invariably unpopular, but the intensity of the public outcry about a program as politically sacred as OASI has been nothing short of remarkable:

> For 40 years, Social Security was the linchpin of all liberal politics. You literally couldn't do too much for the elderly, the disabled and the ill. But now the costs of that largess have come home with a vengeance, and the middle-class working families have let their congressmen hear from them. Never again will Social Security benefits be increased without Congress looking nervously over its shoulder (Broder, 1978).

This tax increase, combined with evidence that the populace has misgivings about the soundness, equity, and investment value of Social Security (Eldred, 1977), suggests that "the peculiar mix of rational self-interest, fiscal illusion, and symbolic manipulations" posited by Mitchell (1977) as the "paradoxical" sources of support for Social Security may be unravelling.

Health is the second major area where the magnitude of current expenditures for the aging is very large and rapidly escalating. Medicare expenditures have risen from $3.2 billion in the program's first year to $16.9 billion in 1976 (Gibson et al., 1977), are budgeted at $29.4 billion for FY 1979, and are projected to be $44.5 billion by 1983 (U. S. Office of Management and Budget, 1978a). Assuming an 11% annual medical inflation rate, Medicare will cost over $90 billion by 1990, and this estimate does not incorporate the increasing numbers of persons who will be eligible for Medicare coverage.[3]

Cost increases in long-term care have been among the most pronounced in recent years and will grow ever larger as the number of persons over age 75 increases 60% by 2000 (Brotman, 1977). While aggregate national health expenditures (public and private) quadrupled between 1960 and 1974, and were up 50% between 1970 and 1974, nursing home costs rose 1500% and 200% during the same periods (Worthington, 1975). In the two-year period, 1974-76, the latter costs have increased another 42%. And, as indicated in Table 1, nursing home costs borne by public programs have also risen steadily.[4]

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[3] Principally because of disability coverage, approximately [illegible] of Medicare expenditures are targeted on persons defined in terms other than age (Social Security Administration, 1978).

[4] Roughly 75% of the nation's total nursing home expenditures are for the elderly (Gibson et al., 1977).

Table 1. Estimated Nursing Home Care Costs.

Year	Total Nursing Care Costs (in millions)	Nursing Care Costs Borne by Public Programs (excluding OASI)	% of Costs Borne by Public Programs (excluding OASI)
1976	$10,600	$5,856	55.2%
1975	9,100	5,014	55.1
1974	7,450	3,801	51.0
1973	6,650	3,264	49.1
1972	5,860	2,465	42.1

Sources: Worthington (1975); Gibson et al., (1977).

Congressional Budget Office (CBO) estimates show long-term care costs continuing their rapid increase. The CBO projects public long-term care costs under current authorizations increasing from the present CBO estimate of $5.7 billion to $15-$17 billion by 1985. Were Medicare home health benefits liberalized to include nonskilled services and were home-based services mandated under Medicaid, the estimated cost of publicly-financed long-term care services would rise to $18-$28 billion by 1985. Long-term care insurance would increase the latter estimate roughly 2½ times (Congressional Budget Office, 1977a). Wershow (1977) estimates that the costs of room, board, and nursing care of the most severely afflicted long-term care patients (organic brain syndrome) could alone rise to $20 billion by 2000.

The costs of publicly supported health policies for older persons are less apparent to the public than is the OASI program, and factors other than the numbers and needs of older people lie behind much of the health cost increases. Nonetheless, the aging currently receive nearly 90% of the services funded through Medicare, 38% of those funded through Medicaid, and 49% of the $48.4 billion of public money spent on health care in the U.S. (Gibson et al., 1977). The proportion of health dollars targeted on the elderly being so substantial, it seems inevitable that political pressures from cost-conscious government officials and benefit-seeking populations will find the aged relatively disadvantaged in new public initiatives in health. The concern older persons might well have is stated succinctly by Anderson (1976):

> In pure self-interest, if I were an elderly person, I would not approve universal health insurance, because resources will not increase in proportion to demand. The aged will then have to scramble for scarcer resources than if the only government program were Medicare. As the pressure on resources builds up in the system, side-effects may include a weakening of the taboo on the "right to die," and an increase in "store houses" for the aged, nursing homes, and old-age homes.

Firm estimates of cost increases in the smaller in-kind programs directed toward the elderly are difficult to make because these are neither entitlement nor, for the most part, means-tested programs. It seems certain, however, that the growth in these programs will be substantially less than in those just discussed. Because they are not entitlement programs, there is no "automatic" cost escalator. Moreover, costs generated by the entitlement programs benefitting the elderly will put added pressures on these discretionary in-kind programs, such as the Older Americans Act. And, to the extent that these programs have been enacted for their non-programmatic or political utility, they may continue to serve their political function without great increases in substantive benefits.

Policy success and improved well-being. — At the same time public expenditures for the aging have been increasing — and in part because of these expenditures — various indices of older persons' well-being have shown improvement. While these developments are welcome and to be expected, they are also serving to alter perceptions of older persons and their needs held by both the population at large and the older population itself. As older persons are shown or perceived to be better off while costs for public programs directed toward them escalate, political pressures on these programs seem certain to increase.

Poverty among the older population has declined sharply in recent years. U.S. Census Bureau (1977) data show the percentage of older persons in poverty declining from 35.2% in 1959, to 28.5% in 1966, to 21.6% in 1971, and to 15.3% in 1975. The University of Wisconsin Institute for Research on Poverty, employing different measures, estimates that only 5% of the older population was in poverty in 1976 (Watts & Skidmore, 1977). There has also been a modest decline in the proportion of older persons in the overall poverty population (Plotnick, 1975a). Principal among the factors in this decline has been public cash and in-kind transfers to the elderly. Foremost among these has been increased OASI benefits. Since the first major benefit increase awarded to retired workers and their dependents in 1950, benefit levels have risen dramatically: 1950: $64; 1955: $129; 1960: $152; 1965: $173; 1970: $227; 1975: $384. While these are current dollar figures, the cost of living has only slightly more than doubled over the same 1950-1975 period (U.S. Office of the President, 1976). Plotnick (1975b) has calculated the probabilities of different demographic groups of the "pretransfer poor" escaping from poverty when cash transfers were factored in. While there was considerable variation among different age groupings, the probabilities for aged individuals (regardless of race, marital status, region, or education) were consistently higher than for younger persons. Widows and elderly Black couples continued, however, to have less than a 50-50 "chance" of being brought out of poverty through these public programs. The Congressional Budget Office (1977b), using complicated modeling techniques, has also estimated the effect of public programs in reducing poverty among older persons. The differential impact of the major income and in-kind programs were calculated to be as shown in Table 2.

Some selected broader measures of well-being also show betterment in the overall status of the aged. Life expectancy at age 65 has increased from 12.8 years in 1940 to 14.4 years in 1960, to 15.6 years in 1974 (U.S. Bureau of the Census, 1975). Death rates for persons aged 75-84 have declined from 112 per 1,000 in 1940, to 87/1,000 in 1960, to 79/1,000 in 1973 (U.S. National Center for Health Statistics, 1976). Between 1958 and 1974, the number of "restricted-activity days" for persons aged 65+ has declined from 47.3 to 38.0 per year (Munnell, 1976). It is important to note, however, that Shanas (1976) found no change in the health status of older persons in her 1975 restudy of the research which she originally conducted in 1962. The higher salaries and wages, expanded private pension coverage, and higher levels of education (Neugarten, 1974; Skolnick, 1976) make it appear likely, nonetheless, that in many aspects of their lives — including, perhaps, health — coming generations of older persons will be better-off.

Table 2. Families Aged 65-and-over Below the Poverty Level Under Alternative Definitions: FY 1976.

	Families in poverty (age 65+) No. (000)	%
Pretax/Pretransfer income	9,297	57.7
Pretax/Post-social insurance income	2,977	18.5
Pretax/Post-money transfer income	2,107	13.1
Pretax/Post-in-kind transfer income	646	4.0
Posttax/Post-total transfer income	654	4.1

Source: Congressional Budget Office, Poverty Status of Families under Alternative Definitions of Income. Background Paper # 17, January, 1977b).

These improvements in the length and quality of life of the older population are changing how the aging view themselves and how others may view the aging and their needs. It is clear and understandable that the aging do not wish to be viewed as dependent or be segregated from the remainder of the population. The Gray Panthers have been perhaps most vocal in demanding social inclusion, but public and private efforts geared toward independent living, elimination of mandatory retirement, and a nonstereotypical media image are each directed toward older persons not being viewed as something apart. Their increased well-being will make these demands more insistent and — at least for the "young-old" — more realistic.

All this will not, however, be without its political consequences. Older persons have received their indisputably high proportion of public benefits in large part because they were, in fact, singularly disadvantaged and were so viewed by other. If — on an aggregate basis — they are now less disadvantaged and wish to be perceived as such, the question of why they should continue to receive special policy treatment immediately arises. Were costs and competitive claims not so pressing, it might be possible for older persons to have an improved existence, a positive image, and disproportionate public benefits. However, these other constraints are present and growing, and it seems likely that, in conjunction with improved well-being and image, they pose a threat to future public benefits. As bluntly put by Samuelson in an article widely circulated in the *Washington Post* (1978), "The more the elderly seem to be enjoying themselves, and the healthier they are, the more young workers may resent it."

Competitive spending pressures. — The third factor portending negative consequences for old-age policy is the contrast between policy benefits which are made available to the elderly and those made available to other population groups. Some of these have been alluded to above and many of the others are widely known, but these disparities will take on increasing political importance as the costs of old-age programs continue to escalate and as the policy needs of the overall aging population come under more careful scrutiny.

Publicly-financed medical benefits are currently weighted heavily toward the elderly, and the bulk of those benefits aid older persons defined officially as nonpoor. While the elderly are confronted by health costs three times greater than the rest of the population, public funds pay 68% of these higher per capita costs while paying only 28% of the lower bills of the younger population (Mueller & Gibson, 1976). Just under 80% of the $23.7 billion in federal health outlays for older persons in 1977 was spent for persons defined as nonpoor as contrasted with 51% of the $18.7 billion spent on behalf of the nonpoor population under age 65 (U.S. Office of Management and Budget, 1977a). Medicare is the major factor both in the high public coverage for older persons generally and for nonpoor older persons in the older population. Its enactment, however, preceded the major economic advances of the older population and the "rise of the young-old." No one advocates or envisages reductions in Medicare benefits, but the status of older persons has undergone some significant changes from what it was depicted to be during the lengthy debate leading up to Medicare's enactment in 1965.

Another unexpected and costly development has been the rising proportion of Medicaid payments targeted on the elderly. Devoted largely to long-term care costs, roughly 40% of Medicaid funds are now assisting the elderly. There can be no question that these benefits are aiding the very neediest of the aged — and often for inappropriate and substandard care — but pressures exist here as well. These rising costs are inevitably impinging on other social-welfare budgets. Testifying before the House Select Committee on Aging, Massachusetts Secretary of Human Services, Jerald Stevens (1977), spoke of these added consequences:

> Because of the escalating costs in Medicaid, we in Massachusetts are not able to provide a cost-of-living increase for AFDC recipients which is a particularly severe burden on the poor people. Additionally, we are not able to provide all the services we think are necessary for either the mentally ill, or for adolescents who need a number of types of care. So, the Medicaid pressure is felt not only in terms of making cuts, or trying to improve management inside Medicaid, but has a very strong ripple effect on all other human service programs — a negative impact on all other human services programs.

The aging have fared relatively well when compared to other social-welfare constituencies in additional areas. AFDC payments never equalled those under the Old Age Assistance Program (Steiner, 1966) and have fallen further behind given the guaranteed minimum and cost-of-living features in the present SSI program. In public housing, where shortages for all eligible populations are chronic, the percentage of units occupied by the elderly has increased markedly, rising from 27% in 1964 to 41% in 1972 (Department of Housing and Urban Development figures cited in Steiner, 1971; and in Gold et al., 1976). Fifty percent of recent public housing construction has been devoted to elderly housing (Steiner, 1971). Recent HUD initiatives to concentrate community development bloc grants in "core" areas are designed in part to assist younger welfare populations at the relative expense of suburban areas where, it has been argued, senior citizen projects tend to dominate.

A number of tax provisions at both the state and federal levels have singled out the elderly for special treatment. In the instances of prescription drug and property tax relief, the rationale lies in the disproportionate burden which falls on the elderly in both of these areas. The double personal-tax exemption and the capital gains exemption for low and moderately valued owner-occupied residences in the federal tax code recognizes the low incomes of older persons. The retirement-income-tax credit seeks to make amends to those elderly who do not benefit from another tax advantage enjoyed by most older persons (viz., the total tax exemption of Social Security and Railroad Retirement income [Schulz, 1976]).

As with publicly-financed health benefits, the issues increasingly coming to the fore concern costs, distribution of benefits within the older population, and inequities between older and younger persons who are similarly situated. The Office of Management and Budget has made the following estimates of the costs (Table 3 — income lost to the Treasury) of different federal tax provisions benefitting the elderly. Despite

Table 3. Loss of Federal Tax Receipts Due to Special Provisions for the Aged.

Special Provision	Loss ($$)
Extra personal exemptions to the elderly	$1.4 billion
Exclusion of Social Security benefits	3.8 billion
Exclusion of Railroad Retirement benefits	.2 billion
Tax credit to the elderly	.2 billion
	$6.0 billion[a]

[a] Total figure is higher than sum of the components because of higher tax brackets recipients would be in were these provisions eliminated.

Source: U. S. Office of Management and Budget (1978b).

the rationale that these tax provisions are designed to aid the low and moderate income elderly, Surrey (1973) estimates that nearly half of the dollar benefits accrue to older persons whose incomes exceed $10,000. And, as is true with exemptions generally, greater benefits accompany higher incomes. The equity issue between older and younger populations is clear, if controversial: younger persons with low incomes, high health-care costs, and nonliquid assets do not share many of the tax advantages enjoyed by older persons (Pechman, 1977).

Political and Policy Consequences

Rising costs of public policies targeted on older persons, improved well-being of the aggregate older population, and continued disparity between policy benefits bestowed on older persons and others in the population are undermining the political legitimacy and utility of the aging, and this decline will bring with it further consequences.

The political legitimacy of the aging has rested in the widespread belief that, as a class of persons, they are singularly disadvantaged by low incomes, poor health, and a particular vulnerability brought on by their place in the life-cycle. This generalized pattern is no longer valid and will become less so with time. The improved status of many older persons is already known in policy circles, but the cost and equity factors are generating questions among the populace at large as to the overall needs of older persons. Furthermore, as cost pressures yield greater opposition to policy initiatives for older persons and as competitive pressures yield separate spending demands, incumbents of elected office will find support of old-age policies more of a mixed political blessing than has been the case. As the policy legitimacy of the aged constituency erodes, so will its utility to other political actors. At least three more proximate consequences will stem from these changes and the pressures producing them.

New appropriations for old policies. — Clearest and most notable in this regard are the new appropriations which will be required to meet existing statutory obligations directed primarily towards older persons. What the Office of Management and Budget classifies as "relatively uncontrollable" expenditures have quadrupled in the last decade, and the rate of increase is accelerating. Obligations for the elderly represent the major element of overall "uncontrollable" spending, which now constitutes nearly ¾ of all federal outlays. Spending under the OASI portion of Social Security, totaling $71 billion in 1977, is expected to rise to over $120 billion by 1983 (U.S. Office of Management and Budget, 1978a). Total outlays for the aging, survivors, and retirees under OASI, civilian and military retirement and insurance plans, Railroad Retirement, SSI, Medicare, and Medicaid were $122 billion in 1977 (author's estimate from OMB figures). The corresponding figure for the FY 1979 budget is $148 billion, or 29.6% of the total budget. HEW Secretary Califano estimates that if present trends continue, "real" spending on behalf of the elderly will triple by 2010 (Califano, 1978). Unfortunately, the factors which contribute to the cost escalation in these areas — number of beneficiaries, levels of benefits, inflation — appear as well to be largely uncontrollable. The first is fixed by demography; the second is constrained by politics; and the third — especially in the health area — has remained nearly impervious to attempts to rein it in.

The principal consequence of these fixed charges is that they severely limit the ability of the government to embark on new initiatives. These costs, coupled with more general budgetary concerns to which they contribute, are already impeding progress in major areas such as national health insurance and welfare reform. But because roughly ½ of the uncontrollable expenditures are attributable to aging-related policies, they can be expected to place a particularly heavy burden on new activities in this area. When an article addressing the escalation in costs of aging policies is entitled "The Withering Freedom to Govern" (Samuelson, 1978), one gets a sense — although perhaps an exaggerated one — of the obstacles which are likely to be encountered.

Locating "new" money to provide greater income, housing, health, and social service benefits for those older persons whose needs and numbers are growing will be very difficult. Tax increases are unlikely for any number of reasons: concern over existing budget deficits, economic problems associated with siphoning off "productive capital" from the private sector, increasing restiveness among taxpayers generally. The further notion that additional revenues should be targeted on the elderly — even those with dire needs — will encounter stiff resistance from taxpayers and competitive constituencies alike.

What largely remains then is reallocating funds earmarked by statute or expectations for other purposes. The question here is simply "whose" pot should be raided? The feeling is widespread in governmental circles and elsewhere that spending for health and welfare functions generally is already excessive; and, within the health and welfare community, it is widely — if not openly — held that "the elderly" get too much. Who will sit idly by and see more spending targeted on older persons if they perceive it to be at their expense?

A third and hardly pleasant alternative lies in reallocating public expenditures for the aging toward those subgroups of the aging population deemed most in need. Despite the valid issues concerning large numbers of relatively well-off older persons receiving significant public policy benefits, reallocation of aging monies raises difficult political and normative questions. The largest single expenditure and the one where the equity issues can be most forcefully argued is in the OASI portion of Social Security. Yet, the benefit structure here — as contrasted with the system's financing — is already progressive, and at least one analyst advocates making it less progressive now that SSI is in place to pick up the "social adequacy" function being served partially by OASI (Munnell, 1976). Medicare currently covers hospital and medical costs which few persons — regardless of age — can reasonably be expected to shoulder themselves. Medicaid benefits are more extensive but are denied to those even with only very modest means. A case can be made for reducing or scaling some of the tax advantages enjoyed by older persons, but only the taxing of Social Security benefits would raise truly significant revenues, and action along those lines is not in the offing in any event. One might expect cuts in the in-kind service programs such as the Older Americans Act, but the revenues freed by such action are not sufficient to finance major new initiatives. It does seem likely, however, that the budgetary growth experienced by these programs in recent years will not continue, a conclusion supported by the President's FY 1979 budget.

A final potential answer to the allocation question involves more cost-effective and, hopefully, appropriate uses of funds contained within the cost-escalation projections presented earlier. Assuming that no downward revisions occur in the cash-benefit estimates for OASI or SSI, the principal item here would focus on health allocations. And, because acute-care coverage is dominated by the medical establishment and deemed fundamental by health-care consumers, the reallocations here are most likely to fall in the long-term care area.

Whether reallocation of long-term care resources — principally away from the current institutionally-based pattern — can lead to monetary savings is a major concern of the Health Care Financing Administration, the Administration on Aging, and other federal and state agencies. No consensus has emerged from the several existing studies related to this question. Relatively favorable cost findings concerning noninstitutional services are reported in Hurtado et al. (1972) study of an HMO population and in the Nielson et al. (1972) study of a posthospitalized population. However, Burton et al. (1974) and Greenberg (1974) report that deinstitutionalization of nursing home patients resulted in very limited cost savings, largely because of the small number of persons in their studies who could be appropriately discharged. Preliminary findings from a panel study by Sager (1977) indicate that for five of nine patients for whom there are discharge data, institutional care was less expensive. Further studies, involving different placement options and subject to widespread replication, will be necessary before it can be determined whether home care and other noninstitutional services can lead to more efficient expenditure of the major resources being devoted to long-term care.

New demands on old agencies. — Budgetary constraints may be only one of a number of new pressures which will be brought to bear on agencies serving older persons. As the older population comes to be increasingly viewed as a public-policy problem rather than as a target of political opportunity, agencies serving the elderly will be placed under new and harder scrutiny. Not only will questions of accountability be raised more frequently, but the questions will be less on the order of "what are you doing for the elderly?" and more along the lines of "what has been the effect of your activities on alleviating pressing needs and controlling growing public-policy costs?"

These tougher accountability questions will be asked of many agencies dealing with the aging such as the Social Security Administration, the Health Care Financing Administration, and the Veterans Administration, but they may be put most directly to the Administration on Aging. Because of its origins, the characteristics of its authorizing legislation, and past perceptions of its role and responsibilities, AoA may find itself hard pressed to provide adequate responses. Historically, AoA has been formally charged with being a "focal point" for governmental concern for the elderly, but the absence of adequate funding, staffing, authority, and concerted outside interest has kept AoA from playing this role, even assuming it was a role AoA wished to play. Instead, AoA has found itself trying to administer a series of fairly large and increasingly decentralized grant-in-aid programs providing a wide array of social services throughout the country. To this point, its serving to recognize the aging as a policy constituency and provide discretionary service dollars has been sufficient to generate requisite levels of political support.

The question now arises as to whether AoA will become the scapegoat for ongoing problems which are not of AoA's making but the resolution of which a revisionist history will claim to have long been the rationale behind its existence. Critics will see a large service-delivery infrastructure and will see as well an increasing volume of unmet needs among an expanding population. Before, it was sufficient to demonstrate that agencies in business to serve the elderly blanketed the country; now, people will search for evidence that there has been some resolution of the problems which these agencies have been established to address. There are, of course, a number of reasons to exonerate AoA, but the questions must be directed somewhere, and AoA is the agency which has had the most proximate responsibility. The agency which serves to recognize a constituency in a benign environment is transformed into a lightning rod attracting problems in a hostile environment. The lofty language expressing concern becomes a legislative mandate demanding results.

Under these conditions, AoA will be under increasing pressure to demonstrate a capacity for problem-solving. While it may continue to lend recognition to the needs of older persons and oversee the disbursement of limited funds for those purposes, it runs the risk of being viewed as just another social-services program under the larger umbrella of the Office of Human Development Services if confined to these roles. The area where AoA might best make its mark appears to be in long-term care, and AoA has, in fact, been making concerted efforts in this direction in recent months. Many of the services currently funded through the Older Americans Act are related to long-term care, but these services have been fragmented, are not confined to persons who have pressing long-term care needs, and are yet to be effectively meshed with the larger array of institutionally-oriented long-term care programs.

There is some leeway for demonstration projects which might show how these current shortcomings can be alleviated, but AoA does not currently have the authority to move the state and area agencies collectively in this direction. These agencies have, in fact, become more autonomous actors within the hierarchy of aging agencies because of their growth relative to other agencies at their respective levels of government and because of the latitude provided them under the Older Americans Act. However, for AoA to maintain a place for itself at the national level, it will increasingly need the capacity to impose a more singular rationale on the program activities under its aegis. An agency's shifting from a constituency-based to a problem-oriented focus carries the danger of losing existing support while seeking it from new and different sources, but the new realities of aging policy in Washington may warrant the risk in AoA's case.

New political pressures on a new policy system. — For the larger aging community, securing additional benefits will increasingly entail overcoming the presence of new resistence and the decline of the legitimacy and utility which have been the mainstays of its political support. Monetary and opportunity costs have caught up with material benefits and perhaps even symbolic ones. Elected officials can no longer lend unquestioned support to aging initiatives, competing interests can no longer remain uninvolved, and budgetary officials on both the legislative and executive side may be decidedly hostile.

The political power of the aging, its extent long the subject of debate, will be put to a sterner test than it has faced to this point. The political legitimacy and utility of older persons have always lent a spurious quality to claims which equate the aging's political power with the policy benefits which they have gained. In the coming period, where scrutiny will supplant sympathy, that question should at least be resolved. Success in securing new benefits and maintaining existing ones will depend as never before on the ability of the aging and their organizations to demonstrate that they have the capability of imposing negative sanctions on those who choose not to support them. Costs and competitive pressures combined with the thought that the aging are not to be slighted will put decision-makers in a new and uncomfortable position when it comes to aging issues. Should they choose to continue supporting aging initiatives, it will be valid testimony to the aging and their organizations having transformed their numbers into an effective political resource.

Even if political pressure generated by the aging turns out to be relatively effective, a question remains as to what ends this pressure will be directed. It will be used if necessary — and probably successfully — to maintain policy gains already won. It is easier to defeat moves to rescind existing benefits than it is to gain enactment of new ones. Beyond defensive actions, the aging constituency will continue to press for liberalization and extension of benefits under existing authorizations. These efforts will include income and in-kind policies alike. Increases in OASI cash benefits beyond those called for under existing formulas will be difficult to bring about, but there will certainly be moves in this direction. Broadening of Medicare benefits will continue to be pressed, but it seems unlikely that significant changes will be made independent of the larger debate on national health insurance. The interests of the aging and those favoring a public presence in the health sector were both well served by Medicare's enactment, but now extension of benefits to new population groups may take precedence over expansion of benefits to the currently entitled older population. Pressures both for and against expansion of social-services benefits will, as indicated earlier, grow more intense.

Largely left out of these efforts and whatever successes they may bring — as has often been the case in the past — will be the most vulnerable of the older population. In proportion to numbers and needs, the income, health, and service benefits directed toward the old-old, the minority old, the isolated, and widowed are slight. That the working years of most of these persons preceded the era of broad private pension and health-care coverage as well as the more recent expansion of public benefits renders them yet more disadvantaged. None of this is, of course, unknown, but ironically recognition of the intense needs of these groups is coming at just the time when the pressures discussed here may constrain initiatives for the entire aging population. If, in addition, the organized aging community — younger, better-off, and now concerned about its own prerogatives — fails to give high priority to the needs of the vulnerable elderly, the latter's well-being may continue to suffer. Responsible elected and bureaucratic leadership will work toward more liberal and appropriate public benefits, but these efforts may be thwarted in the presence of cost-based pressures and in the absence of counterbalancing supportive pressures. For the old-old to be the victims of constraints generated by policies from which they were largely excluded would be reprehensible.

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Item 5

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The Older Americans Act once again faces Congressional reauthorization in 1987. Considered here are the present and future roles of the Aging Services Network that is funded by Title III of the Act. Also discussed are the accomplishments, historical evolution, and current dilemmas of the Network. Various policy options are analyzed. And a proposal is made for amending Title III to establish a nationwide network of Aging Resource Centers for Help (ARCHs).

Key Words: Aging Network, Policy options, Resources for help, Service accessibility, System building

Title III of the Older Americans Act: An Analysis and Proposal for the 1987 Reauthorization[1]

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As the Older Americans Act (OAA) of 1965 faces Congressional reauthorization in 1987, it is timely to reflect upon the role of the Network of Aging Services funded through Title III of the Act. Proposed here is that Congress amend the OAA to convert the present Network into a nationwide Network of Aging Resource Centers for Help (ARCHs).

Introduction

The Title III Network, administered by the Administration on Aging (AoA), U.S. Department of Health and Human Services (DHHS), has accomplished a great deal over the past two decades. When the OAA was first enacted few sectors of American life were even aware of the complex societal challenges generated by population aging, and innumerable day-to-day issues confronted by older persons and their families (see Morris & Binstock, 1966). During the past 20 years the Network has been an excellent vehicle for identifying and emphasizing such challenges and issues, for developing and exemplifying strategies to cope with them, and for providing help to millions of Americans.

Today most sectors of American society are well aware of the challenges and issues of aging. Building upon many of the strategies and methods developed through the Title III Network, thousands of organizations are providing assistance to older persons through public funds and subsidies, philanthropy, the private market, and mixed auspices.

Meantime, federal funding for the Network through Title III has remained limited for many years. Even the latest increase of $51.9 million in appropriations for Fiscal Year 1987 (U.S. Public Law 99-500, 1986) leaves Title III short of the $700 million level, just at about 0.25% of the $270 billion annual federal outlays in benefits to older persons (U.S. Senate Special Committee on Aging, 1986, pp. 94–95).

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To be sure, the Network has drawn upon other sources of funding. A 1982 report (National Association of State Units on Aging & National Association of Area Agencies on Aging, 1982, pp. 6 & 14) suggested that about 49% of the Network's composite annual budget came from 17 other sources than Title III. But a subsequent analysis revealed that in 1984 the Network's agencies in 8 of the 10 federal regions of the country relied on Title III for about two-thirds to four-fifths of their funds (Rosentraub & Naganuma, 1986).

In any event, Title III funding has remained at a relatively steady level during the past decade. And as the challenges of population aging have become increasingly recognized, Congressional leaders have persistently asked whether an annual appropriation of $650 to $700 million for Title III might be used with greater leverage or in a substantially different fashion. Most of these queries have focused on possibilities for changing allocation patterns of funds or eligibility for services within the context of the Network's present mode of operation. Few such possibilities have received wide acceptance, however, and legislative changes in Title III throughout the last decade have been minor. As the U.S. Senate Special Committee on Aging (1985) has observed regarding the OAA, "Based on testimony presented during the 1984 reauthorization, it is clear that Congress will need to go beyond the incremental changes in reforming the act, to enhance and further the goals it set for itself and the Nation back in 1965" (p. 270).

As the 1987 process of OAA reauthorization takes place the Network that has evolved through over 20 years may be confronted sharply with some very basic issues. What is the national policy underlying the continued existence of the Network? Can the funds and efforts expended on it be utilized more effectively in other ways? Can it be built upon and reshaped to play a new role that makes sense in the contemporary context?

Such issues are explored in this essay. The Network is briefly interpreted in terms of: (1) the historical context of the OAA; (2) the contemporary political economy of a perceived scarcity in public resources; and (3) the context of what has been termed the aging society. On the basis of this interpretation a new role is proposed for the Network within its present general magnitude of Title III funding.

The Older Americans Act in Historical Context

The OAA is one of many social development grant-in-aid policies enacted by Congress in the 1960s and 1970s when, for a variety of reasons, public resources for addressing social problems were generally perceived as plentiful. Virtually any social issue that could be well articulated as a matter deserving of national attention became legitimated as an appropriate issue for federal intervention. Congress, rather than risk incurring the displeasure of social issue advocates by resisting requests for innumerable policy initiatives, developed a routine legislative response for dealing with an overload of demands.

Social Service Policies in the 1960s and 1970s

The legislative formula for reacting, detailed elsewhere (Binstock et al., 1985), was to enact social programs that enabled Congress to achieve a number of political goals. Such programs demonstrated Congressional responsiveness to social issues without spending much money. Issue constituencies were appeased by having special earmarked funds through which they could share in "the social pork barrel" (Stockman, 1975). And the generalities of legislation enabled Congress to evade inherent political conflicts embodied in social issues, and to pass them on to the states and localities along with substantial discretionary authority for using a small amount of money.

In general, however, the programs created through this formula did not achieve national social goals. Congress, by papering over latent political conflicts and shipping them out of Washington with money, was in effect creating a series of programs which allowed a wide range of contradictory and disparate actions to be taken through each such program. Moreover, the amounts of funds available for action bore no relationship to the ambitious goals proclaimed in legislation.

Title III of the OAA as a Classic Example

Title III of the OAA, as amended through the present, is a classic example of social policies that evolved through this formula in the 1960s and 70s. It provides funds for services, planning, advocacy coordination, evaluation, and administration to each state that designates a State Unit on Aging (SUA). These SUAs, in turn, subdivide their respective states into Planning and Service Areas (PSAs), and designate an Area Agency on Aging (AAA) as an administrative entity for each PSA. The legislation authorizes AAAs, in accordance with plans submitted to SUAs, to expend federal funds on nutrition services, senior centers, a broad range of supportive and outreach services, *including more than 30 services explicitly described in the statute,* and "any other services . . . necessary for the general welfare of older individuals" (OAA, 1985, Title IIIB, 321).

This omnibus Title III of the OAA is a prototype of the formula for social policy programs that provided Congress with political triumphs in the 60s and 70s. Through legislation of this type Congress demonstrated its social responsiveness. The cadres of state and local entities that received federal funds, as well as their associated service-providing constituencies and interest groups, were grateful supporters of such policies although they inevitably regarded the amount of funds made available to them as inadequate. Citizen constituencies and interests that were unable to gain access to the limited funds may have complained, but national politicians — expressing sympathetic concern — could refer all complaints back to the semi-autonomous state and local implementing agencies. Moreover, excluded constituencies could always be accommodated through inclusion in subsequent amendments, such as the 1978 amendment to the OAA creating a special Title VI, "Grants for Indian Tribes," in response to issues raised by Native Americans. Results could be achieved relatively quickly and tangibly by reporting on the entities and programs established, dollars distributed among constituencies throughout the nation, and the number (and, in some cases, types) of clients served.

Although some (e.g., Estes, 1979) have been highly critical of the Title III Network, it still functions well in this mode of the earlier era. Its accomplishments, recognized and acknowledged by most interested parties, at least include: (1) continuous and dynamic identification of needs of older persons; (2) creation and exemplification of strategies, programs, and services for meeting those needs; (3) provision of tangible and intangible help to innumerable older Americans; (4) development of a nationwide infrastructure of 57 SUAs, 672 AAAs, and about 10,000 associated service-providing agencies, that is in place for helping older persons; and (5) recruitment and socialization of thousands of career professionals and quasi-professionals to the field of aging. But the political environment that nourished this kind of program is no longer with us.

Title III in the Contemporary Context of Scarce Resources

As public resources have come to be perceived as scarce in the mid-1980s, and "reducing the deficit" has become an overriding concern in American political economy, all parties interested in the Network recognize that funding sufficient to provide the more than 30 types of services named in Title III on an adequate nationwide basis would require tens of billions of dollars. And no one has suggested publicly, either recently or in the earlier era, that funds for Title III be increased in such an exponential fashion.

Responses to this context of limited Title III funding have been of two general types (see U.S. Senate Committee on Labor and Human Resources, Subcommittee on Aging, 1984, passim). One response has been to ignore issues of funding while praising the flexibility of the OAA, because it allows for each state and locality to determine its priorities for clients and/or services. The other type of response has been to suggest that the available resources be heavily "targeted" to specific categories of older Americans, or to specific kinds of services and programs.

Title III Policy Issues of Targeting

As indicated earlier, however, one of the more notable features of Title III is its ambiguity with respect to targeting policies to achieve selected social goals.

Among the basic targeting issues that have been addressed but unresolved during the last decade are: Is it desirable to target Network resources to priority categories of older persons or purposes (see, e.g., Binstock, 1978; Crystal, 1984; Kutza, 1981; Neugarten, 1982; U.S. Senate Committee on Human Resources, Subcommittee on Aging, 1979, pp. 304–324), or should its resources be equally available to all older persons and purposes (see, e.g., Cook, 1979; Dressel, 1984; Klemack and Roff, 1981; U.S. Senate Committee on Human Resources, Subcommittee on Aging, 1979, pp. 357–384)? If targeting is desirable, in principle, which of many categories of older persons, programs, and services are appropriate targets and what should be the priorities among them (see U.S. Senate Committee on Labor and Human Resources, Subcommittee on Aging, 1984, passim)? Similarly, if targeting is to be undertaken, which of many different methods that have been identified for operationalizing targeting efforts (e.g., Binstock et al., 1983; Binstock et al., 1984; Crown, 1984; Cutler & Harris, 1983; Harris and Cutler, 1983; Ficke, 1985) ought to be employed? Should targeting Network resources be a responsibility of state and local implementing agencies (see, e.g., Federal Council on Aging, 1981; U.S. House of Representatives Select Committee on Aging, Subcommittee on Human Resources, 1981) or undertaken as a national responsibility?

Such issues of Title III targeting policies have reflected inherent conflicts among the institutional roles and social outlooks of the various parties interested in the OAA and its programs, within a context of limited funding. In principle, these fundamental conflicts could be resolved through federal legislative and administrative initiatives. There are no major technical barriers to doing so (see Binstock et al., 1983). But no initiative to target Title III resources as a matter of national policy can evade substantial political conflict.

Conventional Policy Options for Congress

In 1987 it is doubtful that Congress will be inclined to undertake the political conflicts that any significant targeting initiative through the Network would be highly likely to engender. Especially when one considers that the beneficial impacts that could be expected from redirecting Title III's limited resources to specific categories of citizens or services would be insignificant compared to changes in Medicare, Social Security, and other major programs affecting older persons.

As alternative options Congress could choose to not reauthorize the Network in 1987, or to more-or-less maintain the *status quo* as it has in the last several reauthorizations.

About the only advantage of eliminating the Network — a minor, $700 million annual reduction in federal spending — would hardly be worth the political controversy entailed. The disadvantages seem clear: the cut off of services now funded through Title III; and the negative reaction that would be engendered among clients of the Network, administrators and providers in the Network, state and local public officials, and various interest groups in the field of aging.

The advantages of the *status quo* seem apparent. As evidenced by the 1981 and 1984 reauthorizations, it is the path of least political resistance. Arguments over whether to target resources, to whom, and through which mechanisms would continue to be articulated. But major political conflicts would be largely evaded. The Network and its various political constituencies would be supportive. Meanwhile, Title III programs would continue to help some older persons and their families.

The disadvantages of the *status quo* can be expressed primarily in terms of "opportunity costs," that is, issues concerning the opportunities that may be lost if the Network continues as it is. Could the objectives of the OAA and/or the challenges of an aging American society be met better by expending Title III resources in a different fashion?

The Title III Network in an Aging Society

Even as American perceptions regarding the amplitude of public resources have changed since the 1960s and 1970s, so have our perceptions of the implications of rapid population aging. If anything, the past few years have taught us that an aging society is something very different than an extrapolation of familiar arrangements, practices, and policies driven by mechanisms of demographic change.

Acute care hospitals are acquiring and developing nursing homes; rehabilitation units and hospitals; foster homes; and home care services. Visiting Nurse Associations are becoming joint-venture partners with for-profit home care agencies. Medicare Health Maintenance Organizations (HMOs) have been launched, and experimental Social/HMOs are being tested. About 70 insurance firms are now offering some limited forms of long-term care policies, more than double the number of firms that had been selling them two years ago (Greenhouse, 1986). "Senior citizen" housing projects and retirement communities for "independent living" are finding it necessary to arrange for health and social services as their residents age in place. The world of retirement income has been changed by taxes on Social Security, Individual Retirement Accounts, the Pension Benefit Guarantee Corporation, and a number of provisions in the Tax Reform Act of 1986. Retail firms are using sophisticated techniques to segment the older consumer market (Conlin, 1986).

With such swift changes it would seem that nearly all of us — regardless of age, socioeconomic status, ethnicity, family situation, or geographical location — could use some assistance with issues and problems that confront us. For reasons that need not be reiterated in this forum, older persons and their families may have more than average difficulty in coping with such problems (see Cook & Kramek, 1986; Uehara et al., 1986).

How can any lay person — let alone an older person and his or her family that may be beset by problems of ill-health and disability — for example, sort out the complexities of the health and social care arena? Delivery structures, public and private insurance mechanisms, and terms of benefits and eligibility are shifting everyday. This arena — of Independent Practice Associations (IPAs), Preferred Provider Organizations (PPOs), HMOs, S/HMOs, geriatric assessment centers, ambulatory care units, Skilled Nursing Facilities (SNFs), Intermediate Care Facilities (ICFs), home health agencies, deductibles, co-insurance, Diagnosis Related Groups (DRGs), "accepting assignment," Medicaid and Veterans Administration eligibility, and "Medi-gap" and long-term care insurance — must be as bewildering to older persons and their families as New York City was to the waves of non-English speaking immigrants who came through Ellis Island in the 19th and early 20th centuries. Add in the possibility that an older person beset with one or more health, social, or other problem may have no family, or that the family member(s) may be geographically distant.

In this context, what is distinctive about the Network that has been generated through Title III of the OAA? What is the most useful role it might play?

Most, though not all, of the services that have been developed, advocated, and provided by the Network during the past 20 years are now available through a plethora of public, private, and quasi-public agencies — although availability is uneven, certainly, with respect to some communities. As one example, estimates are that more than 10,000 agencies and organizations in the U.S. are now providing home care services (Nassif, 1987). Services to older persons are now provided on a much larger scale through these other auspices than can be provided through the limited funds available to the Network. (The major exception is the Title III nutrition programs.)

What seems to be missing, however, for most older persons and their families is personal knowledge about such matters as: How and where do they undertake the process of getting help? From which of many agencies can they get help, and on what terms? What kinds of help will they get, and will it be appropriate and effective? Perhaps the most pressing need in our aging society is for a highly visible, distinctive site in every community — that is part of a nationwide, inter-community network of such sites — to which older persons and their families can turn to for beginning the process of getting help, reliably.

The Title III Network is ideally situated to fulfill this need, *if* it can become more visible, in a uniform fashion, in communities nationwide. It has already evolved into an infrastructure of agencies throughout the country. If such an infrastructure did not already exist, we would probably have to build one very swiftly. On the basis of this premise, as well as on the basis of the preceding discussion of the limited options available as the OAA undergoes the 1987 process of reauthorization, a new role for the Network is proposed.

The Proposed Role: A Network of Aging Resource Centers for Help (ARCHs)

The new role proposed for the Network is to serve as a nationwide inter-community linkage of Aging

Resource Centers for Help (ARCHs). The Network of ARCHs would be publicized to become *highly and uniformly visible*, easily accessible sites in each community, for serving as one-stop sources of intake that older persons and their families can rely upon for getting effective help locally, or elsewhere in the nation.

In this role, working collaboratively with the full team of private and public agencies in the community, each ARCH would:

- serve as a source of initial contact and practical information for the client(s) who does not know where to turn;
- provide immediate emergency responses if the presenting situations — such as an episode of acute illness, an instance of physical or emotional abuse, a sudden lack of shelter — warrant;
- with respect to each case that requires a complex, nonemergency response, undertake more extended information gathering, assessments, planning, counseling and assistance, and then implement referrals;
- track the progress of referrals at subsequent, prescheduled intervals;
- re-intervene if tracking indicates that the referral has been ineffective;
- regularly analyze and report on its aggregate activities in order to provide administrative accountability to AoA, maintain ongoing Congressional support for the Network of ARCHs, indicate areas in which the Network of ARCHs needs fine-tuning (e.g., more in-service training, greater capacity, restructuring of operations), and reveal important gaps in the availability of essential services and inter-agency collaboration in a particular community;
- provide leadership, in conjunction with state and community leaders in promoting the development of essential local services and inter-agency collaboration that ARCH operations have identified as lacking.

Although some components of the Title III Network already function in this general mode, few — if any — can carry out the full spectrum of these activities, deal with the comprehensive range of issues and problems presented by older persons and their families, or function as a one-stop, highly visible source of help, and as part of an inter-community nationwide network.

The proposal here is that these activities become the primary or even the sole role of the Network, because this vital role probably cannot be fulfilled effectively by agencies that are involved in the provision of direct services.

Three characteristics essential for performing this role — high visibility as a community source for help; smooth, ongoing collaboration with the full range of existing community agencies; and leadership in further developing services and collaborative activities that are lacking — are virtually impossible for an agency to achieve if it is engaged in direct competition with other local service providers, whether those competitors are non-profit, for-profit, or public. By withdrawing from the role of a service-providing competitor, however, Title III agencies might be able to utilize their legitimacy as officially designated components of the publicly-funded Network to achieve high visibility as a community intake site, collaborative working relations among the full range of existing agencies, and leadership in the development of service resources not available in the community (c.f., Hudson, 1983).

Another, though less important, reason why the Network would need to disengage from service provision is that substantial funds would be needed to make a transition to and function as an effective nationwide Network of ARCHs. Unless Congress is willing to increase Title III funding by $300 to $400 million annually, Title III funds now used for services would need to be reallocated — whether gradually or immediately — in order to free up funds for the ARCH role and activities.

Advantages of the Proposed Role: Why are the ARCHs Different?

In addition to the general arguments presented earlier as to the need for ARCHs, there are other advantages worth noting. First, both the probability that older persons and their families will get help, and the quality of that help, will be improved. The uncertainty of "intake" functions at present — often through police, hospital emergency rooms, physician contacts, pharmacists, and generic social agencies — will be reduced. Second, issues of "means testing," "entitlements," and "moral hazards" would be avoided. Routine ARCH functions, delineating the "natural history" of each case, would enable clients to receive appropriate help within the framework of existing public and philanthropic policies or through the private market. Third, elimination of the Network's direct services would, in some communities, reduce redundancy among services now offered by a multitude of agencies. Fourth, as ARCHs deal with their clients, a solid ongoing record of gaps in services in each community would be established, providing a strong foundation — as contrasted with "needs surveys" — which the ARCHs can use to undertake leadership to develop essential but missing resources. Fifth, the functioning of the ARCHs would build up a strong reservoir of public support, enabling the Network of ARCHs to be increasingly effective on a long-term basis, and add to the capacity of existing and newly-developing agencies to provide help to their clients.

Disadvantages of the Proposed Role

Disadvantages of the proposed role would be largely transitional. First, if the Network's direct services are eliminated, not all such services will be immediately available or accessible from other sources, in the near term. Some current Network clients, and persons who might be clients in the near future, would be deprived of certain kinds of help until eliminated services — that are not redundant —

are redeveloped under other auspices. But if there is need for such services, the routine and leadership activities of ARCHs should lead to their redevelopment swiftly. Second, a transition to the ARCHs role might render obsolete, temporarily, many service-providing agencies and some personnel of the current Network, although the latter could be easily reoriented for ARCH activities. They, their professional organizations, and many advocacy groups in the field of aging would initially oppose the transition, vigorously.

Prerequisites for Transition and Effectiveness

1. *1987 Amendments to the OAA.* — This new role would require a clear Congressional mandate rather than vague legislative language complemented by administrative regulations and "jawboning." The 1987 legislation would need to reallocate the funds now authorized for direct services and designate them for the operation of ARCHs. One possible exception might be the present congregate nutrition programs because: they have been excellent vehicles for sustaining support for the Network within Congress; as opposed to other types of programs, they are not particularly redundant, and are not likely to be developed through other auspices on a widespread basis; maintaining them might be an effective tradeoff to counter Network and client resistance that would be expressed regarding the new role; and congregate nutrition sites could be locations for ARCHs, serving as vehicles to promote the visibility and role of ARCHs. On the other hand, congregate nutrition services presently account for about 50% of Title III funds. If the present funding level is maintained, resources necessary for a Network of ARCHs might be inadequate if they did not include the funds now available for congregate nutrition services.

Careful "costing-out" of the activities of ARCHs would be necessary in any event. If the Network of ARCHs could be operated without reallocating the $348 million that now goes to congregate nutrition programs, then perhaps those programs should be retained. Alternatively, if the total budget for the operation of the ARCHs would require about $700 million, one could make an effective case for retaining the nutrition services and appropriating an additional amount for the new role.

2. *Arrangements for Collaboration and Confederation.* — The role of the Network of ARCHs is premised on effective collaboration with all other community agencies, not competing with them. Consequently, developing an ARCH would require the formation of specific confederative arrangements with the major private and public sector agencies involved with services to older persons and their families in each community.

ARCHs might also develop cooperative linkages with major corporations based in their respective communities, since the latter could play a strong role in enhancing the visibility of ARCHs and might become sources of financial support for ARCH operations. For instance, as Brody (1985) has observed, parent care is becoming a pervasive stress in our society. Corporations are finding that increasingly larger proportions of their employees are involved with parent care issues (Gibeau, 1986; Groomes, 1987). An effective local ARCH, to which employees can be referred, may be attractive to corporate sponsors for maintaining worker productivity, morale, and public relations.

3. *Major Publicity Campaign.* — The effectiveness of ARCHs will depend heavily upon their visibility and accessibility. Although the Network is known to many older Americans, it is safe to say that many millions of older persons and their families do not know that AAAs exist, do not know the names of the agencies, where they are located, or how to get in touch with them. Where the ARCH is, how one gets in touch with it, and its unique role — as a one-stop source of effective help — will need to be common knowledge for older persons and their families who are now befuddled by a number of agencies, names, programs, and policies.

An essential transitional step toward this role will be a major publicity campaign that makes ARCHs familiar and commonplace features of the American scene. In addition to the media, the auspices of state and local governments, non-profit agencies, and private corporations can be used to achieve this objective. For instance, even as telephone numbers for police, fire departments, hospitals, and poison control centers now are made prominent, so could the telephone number of the local ARCH.

4. *Structural Elaboration of the Network.* — Even though the Title III Network has sites throughout the nation, some communities are still lacking readily accessible locations to which older persons can turn for help. Particularly in rural areas and in selected pockets of large cities, the development of additional ARCH sites will be needed.

5. *Reorientation of Network Staff and Staffing Patterns.* — Transition will require some changes in staffing patterns, functions and, in certain cases, different kinds of personnel. Among the prerequisites for this aspect of transition would be intensive staff orientation sessions, using: national training modules that clearly delineate ARCH roles and responsibilities, and relevant national policies and resources; and local training modules providing details on state and local policies and resources. Periodic in-service training and updates of training materials would also be needed since the terrain of policies, agencies, and resources in the public and private sectors is so rapidly changing and complex.

Concluding Observations

The OAA has been extremely valuable over the past 20 years in helping us all to become aware of aging, the issues of aging, and creative and helpful ways to approach those issues. The Network built through Title III has provided help to millions of older Americans and models for thousands of other agencies to provide services. But prospects for substantial further development of the Network in its current mode of operation are limited. As the OAA once again undergoes the process of Congressional reauthorization in 1987, it may make sense for Title III resources to be devoted to a new role.

This essay has suggested that Congress amend the OAA by reallocating Title III funds specifically to support the operation of a highly, uniformly visible, and easily accessible nationwide Network of Aging Resource Centers for Help (ARCHs) to which any older person and his or her family can readily turn to locally, and/or on an inter-community basis, to get effective help in coping with the challenges of an aging society.

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REAUTHORIZATION OF THE OLDER AMERICANS ACT

(Workshop No. 2)

WEDNESDAY, APRIL 19, 1990

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The workshop was held in the Dirksen Senate Office Building, Senator David Pryor presiding.

Staff present: Portia Porter Mittelman, staff director; Christopher Jennings, deputy staff director; William Benson, chief of health and housing policy; John Monahan, professional staff; Anna Kindermann, professional staff; Heather Dreyer, professional staff, and David Barnhart, minority professional staff.

OPENING REMARKS BY JOHN MONAHAN, PROFESSIONAL STAFF, SPECIAL COMMITTEE ON AGING

Mr. MONAHAN. Let me thank everybody for coming. I'm John Monahan. I'm on the staff of the Senate Aging Committee. On behalf of Senator Pryor, we'd like to thank all of you for coming and all of our panelists.

Let me just start off by introducing everybody at the front table here. This is Bill Benson, who is Chief of Health and Housing Policy for the Aging Committee; and Jim Solomon, who is the moderator, who is from GAO. To my left here is Anna Kindermann. She is also professional staff with the Senate Aging Committee.

As I said, Senator Pryor will be joining us, but he wanted to thank you all at the beginning for coming. We appreciate it.

Before I turn it over to Jim I want to introduce David Barnhart with Senator Heinz' staff, who wants to say a couple of words.

STATEMENT OF DAVID BARNHART

Mr. BARNHART. I would like to echo John's statement from Senator Heinz. I'd like to welcome you all to this second seminar. Just to reiterate his feelings on the reauthorization of this Act in 1991, it is very important to him. Again, I'd like to welcome you all and the participants.

Thank you.

Mr. MONAHAN. Thank you, David. I guess I'll just turn it over to Jim now.

STATEMENT OF JAMES SOLOMON, SENIOR ASSISTANT DIRECTOR, PROGRAM AND METHODOLOGY DIVISION, GAO

Mr. SOLOMON. Thank you, John.

My name is Jim Solomon, Senior Assistant Director in the Program Evaluation and Methodology Division of the U.S. General Accounting Office. I'll be your moderator for today's workshop. I want to take this opportunity to welcome you all. We look forward to an open and honest and frank discussion here today.

I'd like to state up front that we, the panel, consider it extremely important that this be a participatory workshop. We, ourselves, can't achieve our objectives alone; we need participation from everyone in the audience. Please consider this a discussion rather than a lecture series.

Let me just talk about the workshop objectives for a second. In preparation for the 1991 reauthorization of the Older Americans Act, the U.S. Senate Special Committee on Aging has decided to hold a series of workshops. The overall objectives of this series are to raise important questions and to propose and assess options for responding to key issues that may merit particularly close attention as part of the reauthorization.

Moreover, the workshops will examine whether the Act remains appropriate for the needs of the elderly in the 1990's.

Today's workshop is the second in a series. It is another step toward reexamination of the Act.

Just as a reminder, the first seminar that we held at the end of January of this year focused on target populations—who gets services and who needs them the most; as well as services—the mix of services offered or possible under the Act; and organizations—the agencies at all levels that are involved in the administration of the Act's objectives and services.

Today's workshop, the second in a series, deals with the issues of (1) information and referral, and (2) information flow in the aging network. Each area will be addressed by a separate panel, but we hope for an exchange of ideas among the panels, as we do from the audience.

Information and referral, also known in the broader sense as "information and assistance," is a vital core of services provided under the Older Americans Act. Services included under I&R can and often do include information giving, needs and capacity assessment, service referral, assistance, client advocacy, screening, and educating communities. That will be addressed by the first panel.

Our second panel will address the equally important concept of information flow. When we think about a national organization comprised of a Federal Administration on Aging with its 10 regional offices, 57 State agencies on aging, 672 sub-State area agencies on aging, and tens of thousands of service providers, we envision a quite extensive network with tremendous amounts of information produced. We will examine possible ways by which the information links can be improved.

Let me just briefly discuss the structure of today's workshop and how we intend for it to go.

As I have already said, the workshop is divided into two sections. From now until about 5 minutes after 11 we will focus on information and referral. Then, after a short break at 11:25, we''ll switch to the information flow topic. For both panels, each member will spend up to 10 minutes addressing a specific issue or program. Then, after all speakers have made their presentations, we'll open the floor up for questions and hopefully a lively and informative discussion.

When you have a question, please come to the microphone in the center aisle, state your name and affiliation, and than make your comment or ask your question. Where appropriate, please identify the panelist to whom your question is addressed.

Again, remember we are here today looking for ideas. The success of this workshop is dependent upon you, the audience, as is our ability to focus discussion and recommend potential changes to the Older American Act as it approaches reauthorization.

I'd like to take this opportunity, as well, to thank all the panel members for joining us, taking time from their busy schedules to come and share ideas with us.

Now, let's get to the business at hand and turn our discussion to information and referral.

In the back of the room is a person that we haven't yet identified. Portia Mittelman is the staff director for the Senate Committee on Aging. Portia, are you back there? There she is waving in the back. Thanks for joining us, Portia.

We are pleased to be joined today by four distinguished presenters who will address their specific I&R programs and provide us with some important insights. Our panelists for the I&R are Doctor Mohamed Al-Ibrahim, Chief, Division of General Internal Medicine, University of Maryland School of Medicine; Ms. Sue Boyd, Vice President of Community Services, Mile High United Way, Denver, CO, joined by Doctor Walter La Mendola, Director of Research and Information Systems for the Colorado Trust; Mr. Robert Logan, Executive Director, Council of Aging in Cincinnati, Inc.; and Doctor Dick Sugiyama, Director of Case Management Program, Seattle-King County Division on Aging.

Each of these panelists will provide information on four aspects pertaining to their I&R programs: first is a brief description of their program, second is unique aspects of their program, third are factors contributing to the success of their program, and fourth will be legislative steps which should be taken to improve the delivery of information and referral services.

With that, I'll turn the floor over to Doctor Al-Ibrahim, Chief, Division of General Internal Medicine and Geriatrics, University of Maryland School of Medicine. He has a strong background in gerontology, including development of a program in geriatric education for the School of Medicine, and serves as chairman of the Geriatrics Task Force at the University of Maryland at Baltimore.

Doctor Al-Ibrahim is deeply and actively involved, and will discuss with us today the Waxter Center for Senior Citizens, a major and unique program displaying just what can be done with academic, private, and public cooperation.

Doctor Al-Ibrahim.

STATEMENT OF MOHAMED AL-IBRAHIM, M.D., ASSOCIATE PROFESSOR AND HEAD OF DIVISION OF GENERAL INTERNAL MEDICINE, UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE, BALTIMORE, MD

Dr. AL-IBRAHIM. Thank you, Mr. Solomon, panel members, and ladies and gentlemen.

This presentation will attempt to cover three areas. First a medical program model will be described where academia and private groups work in partnership with local agencies in the planning and provision of services and education for the elderly. Unique aspects of this program will be described, as well as some of the problems encountered. Finally, we will propose that area agencies on aging and private sector partnerships be encouraged and that consideration be given to support the development of an information system that would link agencies responsible for information, referral, and resource allocation with acute care hospitals.

Our program is located in Baltimore within the Waxter Center for Senior Citizens. The Center was financed through a bond issue passed by the citizens of Baltimore City in 1967, and the building was completed in 1974. The Waxter Center is now one of the largest and most comprehensive senior centers in the United States. The three-story building, with over 55,000 square feet of interior space, houses an auditorium; classrooms; dining, vending, and recreational areas; special areas for physical therapy; and a day care program serving frail elderly.

The Center is operated and supervised by the Baltimore City Commission on Aging and Retirement Education, which is the local area agency on aging. It is supported by funds from Federal, State, and city agencies and by donation of its members and other concerned citizens.

The medical services at Waxter make up the ambulatory geriatric program of the Department of Medicine of the University of Maryland School of Medicine. In addition to the School of Medicine, five other professional schools—Nursing, Social Work, Law, Dentistry, and Pharmacy—at the University of Maryland at Baltimore Campus are involved in Waxter Center programs. These schools support Waxter Center activities by the participation of their faculty in Waxter programs and by providing many in-kind services to the Waxter.

The relationship of UMAB—University of Maryland at Baltimore—to the Waxter Center began in 1977 as a response by university faculty to the Federal Area Health Center Program—AHEC. The faculty argued that distribution of health professionals occurred not only on a regional and specialty basis, but also on a population basis. As a result, the university proposed a population-based AHEC as a supplement to a geographic AHEC program. In 1977, UMAB was awarded a 6-year contract to develop the geriatric AHEC.

At the completion of Federal funding in 1983, the geriatric AHEC continues to operate under the auspices of the University-supported program of statewide AHECs. During the past 10 years, the Waxter/University partership has become one of the largest and most successful geriatric AHEC programs in the State.

Waxter Medical Services are under the direction of the Department of Medicine, and all the activities relate to the Director of the Waxter Center. The coordination of all health-related activities are under contract to the Baltimore City Commission on Aging and to the Baltimore City Health Department. Waxter Medical Services is a full-time, comprehensive medical and educational program. It provides medical, dental, psychiatric, and podiatry services.

There is a wide array of screening and preventative activities which extend to outreach sites. Over 1,000 persons are enrolled in the private practice. There is a physician house call service and specialty consultations in arthritis, gastroenterology, and clinical pharmacy.

An interdisciplinary, comprehensive geriatric assessment program serves frail elderly, many of whom are referred by I&R services in the city.

Educational programs for elderly are maintained through screenings, health fairs, and lectures. Arrangements with local pharmacies have resulted in special programs which include medication packs, drug education, and home delivery.

The program provides consultation to a variety of agencies and maintains linkages with legal counsel in matters pertaining to guardianship, competency, and estate planning.

Inpatient care for our patients is provided at several hospitals. A formal, interdisciplinary discharge planning process reviews all medical patients at University Hospital. The development of a satisfactory patient care plan at the time of hospital discharge has become increasingly important and difficult. Hospital stays are shorter, the severity of illness at the time of hospital discharge is greater, and the complexity of outpatient and home care has increased by the availability of new technologies and resources.

The Waxter Geriatric AHEC in Baltimore has realized its major goals and objectives. The Waxter Center is a model educational site that provides quality clinical experience to pre- and post-graduate students and faculty of all six University of Maryland professional schools.

For the citizens of the city, a wide array of health services and education are available to the elderly at the Waxter Center and several outreach sites.

The overall success of the program notwithstanding, there remain a number of problems. Budget constraints in Baltimore City have resulted in cutbacks in the contractual agreement with Waxter Medical Services. These cutbacks amount to almost a 50 percent reduction from 1987 to the present, and threaten particularly the viability of screening and the educational activities.

The private practice, although thriving, has not been profitable. For the most part, it is a primary care practice for the large population of frail elderly and is labor intensive. Screening and preventive activities greatly exceed those specified in the contract with the city, and most cannot be reimbursed by third-party payors. The geriatric assessment program and the house call service have always operated at a financial loss. The lack of case managers poses many obstacles, since case managers can guide patients and clinicians to negotiate the systems through which services and resources can be identified.

Patient care is also hampered by inadequate information linkages with acute care hospitals where patients at rtisk are often identified. Hospital discharge planners must be linked with agencies and case managers in the community. Without this link, optimal discharge planning will be jeopardized.

During the past 3 years, the Maryland program for Geriatrics and Gerontology Education and Research (GGEAR), also based at UMAB, has been actively working with AAAs and the Division of Health Information Resources Management at the University of Maryland. Updated listings of all geriatric services and resources in the State have been maintained. A computerized listing of all geriatric education, curricula, and research projects and resources has also been developed. In addition, data collection forms for all AAAs have been revised with new coding schemes.

The GGEAR program and the Division of Health Information Resources will compile, store, and maintain the data base which will be made available to AAAs on a county basis. It is not clear how far this funding will extend; however, there are no plans to link the system to hospitals or other clinical sites.

In the model of long-term care which I described, integration and continuity of patient care have been made possible by the development of the relationships described and by the manual linkages amongst a group of providers who share a common academic base. Whenever a client moves outside this loop, continuity is broken. Often this results from an unplanned hospitalization, emergency room visit, or nursing home stay.

For the reauthorization of the Older American Act in 1991, we first recommend that specific funds be set aside for joint ventures between AAAs and private sector for program development. Also, we recommend support and funding for demonstration projects that would improve information transfer via a database that would maintain medical, sociological, and functional client information. This database should link health providers with available community resources for the elderly.

The proposed information system can facilitate resource and patient tracking and reduce duplication of services and minimize fragmentation of care.

Implementation of such an information system must address clinical questions. Which group among the elderly should be targeted? Where and how will we find these individuals?

It must also address technical questions. What information about clients and patient episodes are we to collect? Where will the information be stored? Who will maintain the integrity of the information system?

Last, ethical and legal questions must also be addressed. Which individuals or agencies will access the information? How will the information be retrieved? And how will privacy and confidentiality be protected?

Data from a variety of sources allow us an overview of the annual flow of American elderly through the health care and social welfare maze. Each year for every 100,000 community-dwelling elderly approximately 80,000 will see a physician at least once, and 31,000 will require hospitalization for acute care. Those 31,000 individuals will actually generate 44,000 hospital discharges over the course of a year.

Many of those who require hospitalization will be frail elderly with multiple medical and psycho-social problems. While hospitalized, these individuals should have a comprehensive, interdisciplinary assessment. This assessment is extremely valuable, but at present is not usually available to the community provider once the patient is discharged.

We propose that the acute care hospital be the point of entry for the target group and that the group of elderly often described as frail be the target group. The indicators for fraility will have to be defined.

Hospitals already have automated information systems, and some have a well-developed discharged planning process. If acute-care hospitals could be linked to AAAs, they would have access to the I&R network. The process of discharged planning would be greatly improved, and hospitals would also have access to case management.

After discharge from the hospital, allocation of resources could proceed more effectively and in a timely manner. Timeliness is particularly more and more important since more traditional caregivers, such as spouses and daughters-in-law, are entering the job market.

The proposed system, once in place, should be validated through sound research methods. This information netrwork will result in continuity of care to the frail elderly and the system will also facilitate tracing of resources and individuals and will suggest methods for minimizing duplication, maximizing efficiency, and reducing costs.

Thank you.

[The prepared statement of Dr. Al-Ibrahim follows:]

U.S. SENATE SPECIAL COMMITTEE ON AGING

AND

U.S. GENERAL ACCOUNTING OFFICE

SEMINAR:

REAUTHORIZATION OF THE OLDER AMERICANS ACT

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Baltimore, Maryland

April 19, 1990

Dirksen Senate Office Building
Washington, D.C.

AN INFORMATION SYSTEM TO SERVE FRAIL ELDERLY

This presentation addresses three areas. First, a medical program model will be described where academia and private clinical groups work in partnership with local agencies in the planning and provision of services and education for the elderly. I will describe unique aspects of this program as well as some of the problems encountered. Finally, we will propose that support be given to develop a new type of information system that would link agencies responsible for information, referral, and resource allocation with acute care hospitals.

Background: Our program is located in Baltimore within **The Waxter Center for Senior Citizens.** The Center was financed through a bond issue passed by the citizens of Baltimore City in 1967. The philosophy that motivated the bond issue and still guides the operation of the Center emphasizes prevention of illness, the socialization process, and maintenance of independence. The Waxter Center, completed in 1974, is now one of the largest and most comprehensive senior centers in the United States. The 3-story building with over 55,000 square feet of interior space houses an auditorium, classrooms, dining, vending, and recreational areas. In addition, there are suites for medical, dental and podiatry services and special areas for physical therapy and a daycare program serving frail elderly. The center, operated and supervised by the Baltimore City Commission on Aging and Retirement Education,is supported by funds from Federal, State and City agencies and by donations of its members and other concerned citizens.

The Medical Services, at the Waxter Center make up the ambulatory geriatric program of the Department of Medicine of the University of Maryland School of Medicine. In addition to the School of Medicine, the five other professional schools (Nursing, Social Work and Community Planning, Law, Dentistry, and Pharmacy) at the University of Maryland at Baltimore (UMAB) campus are involved in Waxter Center programs. These schools support Waxter Center activities by the participation of their faculty in Waxter programs and by providing many in-kind services to the Center.

The relationship of UMAB to the Waxter Center began in 1977 as a response by University faculty to the federal Area Health Education Center (AHEC) program created by Congress in 1972. The AHEC concept was created for the purpose of addressing the problem of maldistribution of health care personnel. AHEC funds supported the development of offsite training activities that enabled students to become familiar with the health care needs of particular underserved geographically-located groups. University of Maryland faculty recognized the need to improve existing attitudes of providers and institutions to the needs of the elderly. They argued that maldistribution of health professionals occurred not only on a regional and specialty basis but also on a population basis. As a result, the University of Maryland proposed a population-based AHEC as a supplement to the geographic AHEC program. In 1977 UMAB was awarded a six year contract to develop the Geriatric AHEC. At the completion of Federal funding in 1983, the Geriatric AHEC operates under the auspices of a University supported program of Statewide AHECs. During the past ten years, the Waxter-University partnership has become one of the largest and most successful Geriatric AHEC programs in the State.

The Current Status of Waxter Medical Services

Waxter Medical Services consist of a wide array of health services under the direction of the Department of Medicine; all of these relate to the Director of the Waxter Center. The coordination of all health related activities are under contract to the Baltimore City Commission on Aging and Retirement Education and to the Baltimore City Health Department. Waxter Medical Services operate throughout the week and make available the following services:

o Screening and Preventive Care. Blood pressure checks; screening for breast, cervical, colo-rectal and prostate cancer; diabetes and glaucoma screenings; cholesterol determinations; and hearing examinations are all dispensed at no charge to the patient.

o Physician Services to the Waxter Adult and the Hooper Alzheimer's Daycare Programs. These include health assessment of clients, participation in team conferences and emergency medical coverage.

o Health Monitoring Clinic. A one-time comprehensive physical examination is offered to City residents over 60 years of age at no charge. This clinic functions as a resource to a number of sponsored programs. Examples are providing health assessments and medical clearance for individuals interested in exercise classes, Foster Grandparent, and Senior Companion Programs.

o Dental Services. A private dentist group furnishes a full range of services available at reduced fees through a variety of payment plans.

c Podiatry Services. A private podiatry group provides services four half days per week.

o Comprehensive Geriatric Assessment Program. This interdisciplinary assessment program is designed to meet the needs of frail elderly and is highly responsive to referral agencies which serve elderly. In addition to in-depth evaluation, the assessment also includes a home visit. Many of the referred clients are at a crisis level with multiple medical and psychosocial difficulties. The Geriatric Assessment Team consists of a social worker, physician, psychiatrist, dentist, pharmacist, and physical therapist.

o Medical Private Practice. Over 1,000 individuals receive continuity care and twenty-four hour physician coverage by faculty physicians from the Department of Medicine.

o Specialty Consultation Services. These services include Arthritis, Gastro-enterology and Psychiatry. Urological and expanded Clinical Pharmacy consultations will be available in the near future.

o Physician Housecall Services. The physician housecall program was started in 1986 as a federally funded demonstration project designed to teach medical students about housecalls and the home environment of their older patients, and continues on a regular basis.

o Influenza Vaccination Program. Influenza vaccinations are made available every year during October and November. Over 1,000 vaccinations are given annually at no charge to Baltimore City seniors.

o Maintaining linkages with legal counsel in matters pertaining to guardianship, competency and estate planning.

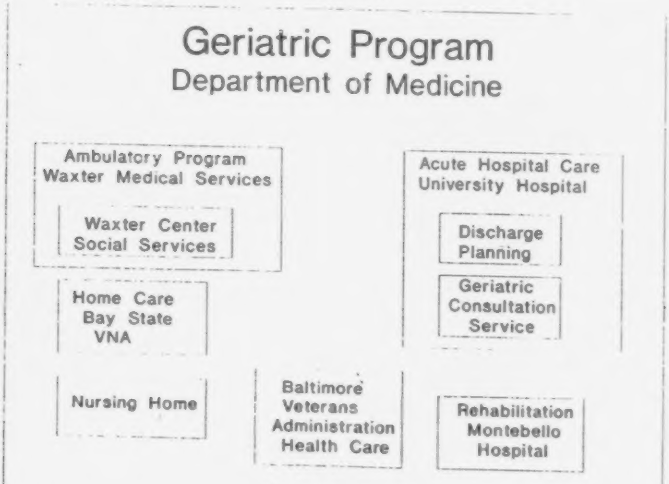
o Coordination of placement and scheduling of students and trainees.

o Maintaining an educational program for clients and consumers through health fairs, lectures and other institutional formats. Waxter Medical Services also provide advice on all health related matters to agencies located within and outside the Waxter Center.

o Working with local pharmacies to develop special programs for the elderly including special medication packs, drug education, and home delivery.

Inpatient care for our patients is provided at University Hospital, the Veterans Medical Center and Kernan Hospital and inpatient rehabilitation at Montebello Hospital (Figure 1). A formal interdisciplinary discharge planning process reviews all medical patients at University Hospital. The development of a satisfactory patient care plan at the time of hospital discharge has become increasingly important and difficult. Hospital stays are shorter, the severity of illness at the time of hospital discharge is greater, and the complexity of outpatient and home care has increased by the availability of new technologies and resources.

FIGURE 1


Geriatric Program
Department of Medicine
Ambulatory Program
Waxter Medical Services
Waxter Center
Social Services
Acute Hospital Care
University Hospital
Discharge
Planning
Geriatric
Consultation
Service
Home Care
Bay State
VNA
Nursing Home
Baltimore
Veterans
Administration
Health Care
Rehabilitation
Montebello
Hospital

Analysis of the Waxter Medical Program.

The Waxter Geriatric AHEC in Baltimore has realized its major goals and objectives. The Waxter Center is a model educational site that provides quality clinical experience to pre- and post-graduate students and faculty of all six University of Maryland professional schools. Repeated evaluations demonstrate a high degree of satisfaction among students and faculty with their experiences at Waxter. Student attitudes and knowledge about the elderly have improved substantially. For the Citizens of Baltimore a wide array of health services and education are available at the Waxter Center and several outreach sites.

The overall success of the program notwithstanding, there remain a number of problems and obstacles. Budget constraints in Baltimore City have resulted in cutbacks in the contractual agreement with Waxter Medical Services. In real dollars, these cutbacks amount to almost a 50% reduction from 1987 to the present and threaten the viability of screening and educational activities. The private practice, although thriving, has not been profitable. For the most part it is a primary care practice with a large population of frail elderly and is labor intensive. Screening and preventive activities greatly exceed those specified in the contract with the City and most cannot be reimbursed by third party payers. The geriatric assessment program and the housecall service have always operated at a financial loss. The lack of case managers poses many obstacles; case managers can guide patients and clinicians to negotiate the systems through which services and resources can be identified. Patient care is also hampered by inadequate information linkages with the acute hospital where patients at risk are often identified. Hospital discharge planners must be linked with agencies and case managers in the community. Without this link, optimal discharge planning will be jeopardized.

During the past three years the Maryland Program for Geriatrics and Gerontology Education and Research (GGEAR) which is based at UMAB has been actively working with Area Agencies on Aging (AAoA) and the Division of Health Information Resources Management of the University of Maryland. Updated listings of all geriatric services and resources in the State have been maintained. A listing of all geriatric education curricula and research projects and resources has also been developed. In addition, data collection forms for all AAoA have been revised with new coding schemes. The GGEAR Program and the Division of Health Information Resources will compile, store and maintain the database which will be made available to AAoA on a county basis. However, there are no plans to link this system to hospitals or other clinical sites.

In our system of long-term care, integration and continuity of patient care have been made possible by development of the relationships described earlier and by the manual linkages among a group of providers who share a common academic base. Whenever a client moves outside this loop, continuity is broken; often, this results from an unplanned hospitalization, emergency room visit, or nursing home stay.

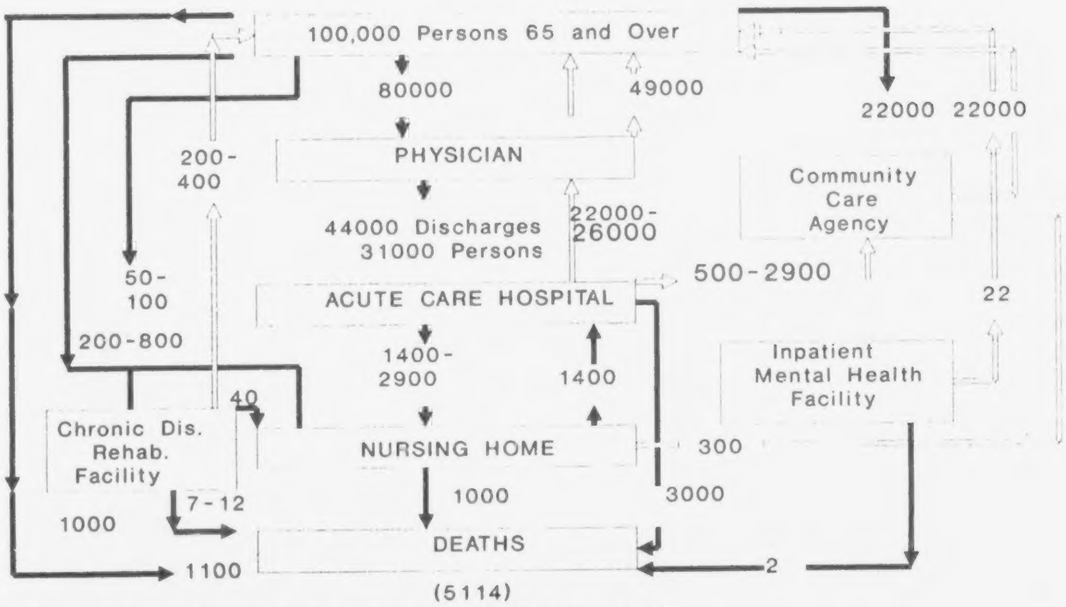
Recommendations: In the Reauthorization of the Older American Act in 1991, we recommend support and funding for demonstration projects that would improve information transfer via a database that would contain medical, sociological, and functional client information. This database should link providers with available community resources for elderly. Older individuals have needs which must be met by services at several different sites, delivered by many different providers over a period of many months or years. The proposed information system can facilitate resource and patient tracking, reduce duplication of services and minimize fragmentation of care.

Implementation of such an information system must address clinical, technical, and ethical-legal questions: Which group among the elderly should be targeted? Where and how will we find these individuals? What information about clients and patient episodes are we to collect? Where will the information be stored? Who will maintain the integrity of the information system? Which individuals or agencies will access the information ? How will the information be retrieved? How will privacy and confidentiality be protected?

Rationale: Data from the National Health Survey, the U.S. Senate Special Committee on Aging, The American Association of Retired Persons, and state reporting systems allow us an overview of the annual flow of American elderly through the health care and social welfare maze. Each year, for every 100,000 community-dwelling elderly, approximately 80,000 will see a physician at least once and 31,000 will require hospitalization for acute care. Those 31,000 individuals will actually generate 44,000 hospital discharges over the course of a year (Figure 2). Many of those who require hospitalization will be frail elderly with multiple medical and psychosocial problems. While hospitalized, these individuals should have a comprehensive interdisciplinary assessment. This assessment is extremely valuable but is not usually available to the community provider once the patient is discharged. We propose that the acute care hospital be the point of entry for the target group and that the group of

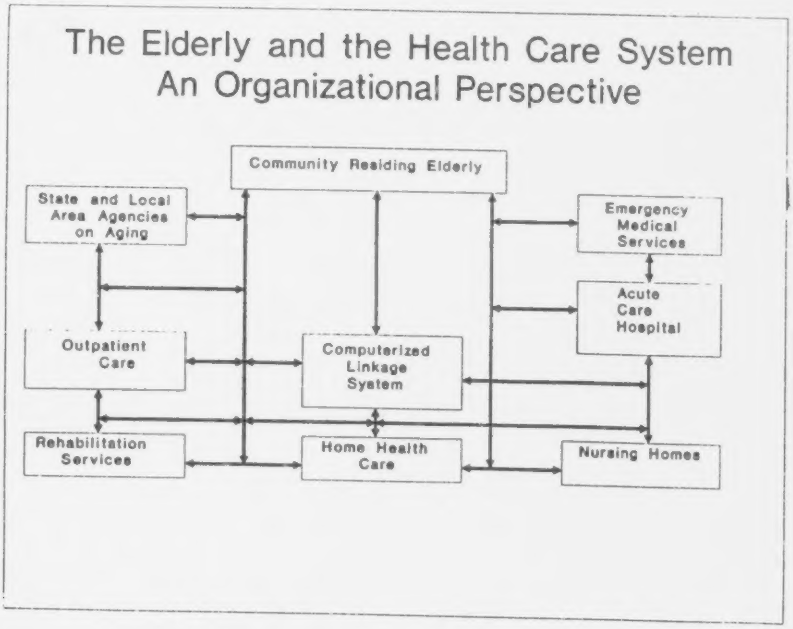
FIGURE 2

Annual Movement of Persons 65 and Over through the Health Care System


100,000 Persons 65 and Over
80000
49000
PHYSICIAN
200-400
44000 Discharges
31000 Persons
22000-26000
50-100
ACUTE CARE HOSPITAL
500-2900
200-800
1400-2900
1400
40
Chronic Dis. Rehab. Facility
NURSING HOME
300
7-12
1000
1000
3000
DEATHS
1100
2
(5114)
22000
22000
Community Care Agency
22
Inpatient Mental Health Facility

Adapted from Milbank Quarterly, Vol 65, No 4,1987 elderly often described as "frail" be the target group. The indicators for frailty will have to be defined. Hospitals already have automated information systems and many have a well-developed discharge planning process. If acute care hospitals could be linked to AAoA (Figure 3), they would have access to the information and referral network. The process of discharge planning would be greatly improved and hospitals would also have access to case management. After discharge from the hospital, allocation of resources could proceed more effectively and in a timely manner.

Figure 3


The Elderly and the Health Care System
An Organizational Perspective
Community Residing Elderly
State and Local Area Agencies on Aging
Emergency Medical Services
Acute Care Hospital
Outpatient Care
Computerized Linkage System
Rehabilitation Services
Home Health Care
Nursing Homes

Partnerships between Area Agencies on Aging and the private sector should be promoted in this effort. The proposed system, once in place, should be validated through sound research methods. This information network will result in continuity of care to the frail elderly. These systems will also facilitate tracking of resources and individuals and will suggest methods for minimizing duplication, maximize efficiency and reduce cost.

Mr. SOLOMON. Thank you, Doctor Al-Ibrahim.

I've got about 100 questions. It is hard to hold them all until the end, but I will. I have to follow the rules like everybody else.

Our second presenters joined us from Denver, CO, and they are: Sue Boyd, who has been employed in a nonprofit, human service organization for 13 years. After completing an MBA at the University of Colorado in 1985 she went to work for the Mile High United Way, where she is currently the Vice President for Community Services. She is joined by Walter LaMendola, Ph.D., Director of Research and information systems at Colorado Trust. He designed the ElderNet system that we will be talking about today.

Sue.

STATEMENT OF SUE BOYD, VICE PRESIDENT OF COMMUNITY SERVICES, MILE HIGH UNITED WAY, DENVER, CO, ACCOMPANIED BY WALTER LaMENDOLA

Ms. BOYD. Thank you.

Let me start out by saying that I am more of an expert in I&R services than aging services. Walter LaMendola is the technical expert on this project.

The ElderInfoNet project began three years ago with the recognition that there was a problem in Metro Denver associated with senior access to information about services.

In a 1987 study that was funded by the Colorado Trust, the fragmentation of I&R services was identified as a key problem in Metro Denver. With additional funding from the Colorado Trust, the AAA convened a consortium of key service providers in the Metro Denver area which met over a year and a half period of time to design the eight-county I&R network now known as ElderInfoNet.

Miles High United Way assumed leadership for the project when the consortium identified it as the most viable candidate to become the systems manager during implementation. Mile High United Way was already operating the community's most comprehensive I&R service. It was also maintaining the largest metrowide database and that database was already being used by many other I&R providers.

There are several key components to this project. One of the most important is the development of an integrated, automated database of service information which is maintained by a consortium of nonprofit and government agencies through contractual arrangement with Mile High United Way.

The development of this integrated database is intended to address the problem of duplicate efforts to maintain the same information. It is also intended to create a larger, more comprehensive, and better-quality database that will be accessible to more providers of I&R and direct client services.

This database is being built on a common software base. The software is known as Community Services Locator. The database will be available to other providers in computerized format, as well as directory and Rolodex formats.

Another important part of this project is a telephone network that will include all of the agencies in the consortium I just described. The telephone network will allow callers—individuals who are seeking services—to enter the information and referral system at any point and be transferred to service providers or other I&R services without having to redial.

Another key component is I&R training for all users of the system. One of the problems that was identified early on was the varied quality of I&R provided from one service provider to another.

The project also includes a major public relations and marketing effort intended to increase public awareness of the system and how to access it. The AAA in Metro Denver will assume primary responsibility for this effort.

Finally, the problem of inconsistent and poor quality service data is something we hope to overcome with this project. The computerized database and referral system will allow compilation of more comprehensive client service information from all providers.

Some unique aspects of this project include the public/private partnerships that are involved in this effort. One key to the project's continued success is a consortium of participating agencies which serves as an advisory group to the project.

Mile High United Way has taken over management of the system, but continues to take operational issues to the consortium for their guidance. An example of how this has worked is the collective thinking put into formatting of the database to make sure that it is meeting the needs of all different kinds of I&R providers.

It is important to note that this project is not fully up and running yet. It has created a lot of interest, even though it does not yet have a track record. We do expect to have a public marketing plan in place by late 1990, and the database to be available to other service providers in 1991.

There are some important aspects related to the success of this project that are worth noting. The aging service providers in Metro Denver are notorious for disagreeing among themselves, but this group has held together over nearly a 2-year period. Factors that seem to be contributing to the success of that effort are its collaborative nature, the focus on a common goal, the commitment of the funder—the Colorado Trust. These have been important to overcoming barriers.

Another element contributing to success was the low-cost nature of the PC-base network that has been designed to handle the database for the project.

Among other unique aspects of the project are the public/private partnerships that are evolving as the project is being implemented. We do not yet have all the answers related to issues of such partnerships but we are learning as we make our way through implementation of the project.

Another important thing to note is that we anticipate implementation of this project will serve as a pilot for application of the model to another service areas. This is important in terms of Mile High United Way's role in the project. Mile High United Way's commitment is part of its commitment to a bigger spectrum of I&R services to the public designed to meet a broad spectrum of family needs.

There are a few issues that remain to be addressed, and we feel that they may have some implication for future legislation.

One of the issues that has arisen is how to reach the elderly public through small community agencies and outreach. United Way, through its needs assessment, has identified reaching low-income and minority aging populations as one of the most difficult challenges in this service area. Small community agencies which may have the most potential to reach these populations are also agencies that lack resources to participate in more sophisticated systems of this type.

The question remains: whose responsibility should it be to meet this need, and how should it be funded?

Another area that is creating some interesting issues for us in implementing this project is the impact of competing national efforts to manage work place contracts to provide elder care.

Local agencies are driven by the prospect of revenues generated by such contracts, but such contracts do interfere with the efforts of local projects like this. Variable data requirements make it difficult to build compatibility and consistency in a system intended to meet broader community needs that are not necessarily met through the work place.

Again, we do not have answers but have recognized issues that need to be addressed.

I think that closes my comments.

[Prepared statement of Ms. Boyd follows:]

ElderInfoNet

"A Collaborative Information and Referral Project in Metro Denver"

Background

A 1987 study, funded by The Colorado Trust, identified the fragmentation of information and referral (I&R) services for the elderly as a key problem in the metro Denver area. With additional grant assistance from The Colorado Trust, the local Area Agency on Aging convened a Consortium of key service providers, including Mile High United Way, to plan for more coordination of I&R services for the elderly. The group developed a proposal to create an eight-county I&R network including an integrated, automated database to be used by all participants in the network. Because Mile High United Way's database was the community's largest and most comprehensive one (already being used in directory format by most I&R providers which were not maintaining their own database), the Consortium and The Colorado Trust identified Mile High United Way as the most viable candidate to assume the responsibility of Systems Manager for the project. A subsequent grant was awarded to Mile High United Way by The Colorado Trust to implement the project.

Key Components of the Project

- o A common software base known as Community Services Locator.
- o A central database maintained by government and non-profit agencies bound by contractual arrangement with Mile High United Way, the System Manager, to collect and update assigned segments of the database on an ongoing basis.
- o Service provider access to the database to be provided on a subscription basis in the following formats:
  - Computer diskette (for agencies equipped with the Community Services Locator software)
  - Rolodex
  - Directory
- o Public access to the database through participating service providers and other means.
- o A telephone network that allows callers to enter the network at any point and be transferred to other service organizations without re-dialing.
- o I&R training for system users.
- o A promotion plan to increase public awareness of the system and how to access it.
- o A Consortium of agencies, including the Area Agency on Aging, committed to work together in a policy-making and advisory capacity to the project.

Tentative Timelines

- System setup, testing, and debugging - January - August 1990
- Public marketing campaign to begin - Fall 1990
- Database available to new subscribers - 1991

Unique Aspects of the Project

- Collaborative design of the project and the public/private partnerships that are evolving as the project is implemented.
- Expectation that software selection and United Way's role as Systems Manager will lead to more timely application of the I&R network model to other health and human service areas; opportunity to integrate information and services to meet a broader spectrum of individual and family needs than is possible with a single service area focus.

Key Issues That Remain to be Addressed

- Senior access to information through small community agencies with the greatest neighborhood outreach capacity but the fewest resources to effectively access and utilize sophisticated information systems; both a funding and responsibility (public and/or private?) issue.
- Impact of competing nationwide efforts (i.e., Work Family Directions and others) to manage workplace contracts through local agencies; agency decisions, re: database software, (key component of any network design) driven by greatest source of potential revenue (i.e., workplace contracts) rather than total needs of the community.

For More Information

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Denver Regional Council of Governments
2480 West 26th Avenue
Denver, CO 80211
(303) 455-1000

Mr. SOLOMON. Thank you, Sue.

Our next presenter will be Mr. Robert Logan, Executive Director, Council on Aging of the Cincinnati Area. Mr. Logan has been involved in managing organization, making up parts of the aging network since receiving his graduate degree in public administration and urban studies from the University of Akron in 1976.

Positions Mr. Logan has held include Director of the Sycamore Senior Adult Multi-Service Center and Assistant Director, and then currently Director of the Council on Aging of the Cincinnati Area.

Mr. Logan will discuss the activities of this major and innovative program under his direction. I'm not going to mention the Cincinnati Reds' winning streak.

Bob.

STATEMENT OF ROBERT LOGAN, EXECUTIVE DIRECTOR, COUNCIL ON AGING IN CINCINNATI, INC., CINCINNATI, OH

Mr. LOGAN. That's all I wanted behind my name—eight in a row—but that's fine. [Laughter.]

In all major metropolitan areas there exist systems which are designed to serve the at-risk elderly. These systems often are not well coordinated, are cumbersome to access, and at times generate duplication of service. To maximize efficient use of limited private and public funding for long-term care, it is essentially to carefully screen individuals seeking assistance. Clearly elders' need and request for assistance will vary in intensity, immediately, and potential cost. More clients need only accurate information, some need assistance with contacting service providers, and others need a comprehensive package of services. The more impaired the elderly, the more likely he or she is to require more intensive service response.

Thus, the living at home care coordination system operates on the principle of one-stop shopping. It is an easily accessible system set in place to supply information, assistance as needed, and referral to case management for clients with more complex needs—particularly with deficits in functioning and informal supports.

The living at home care coordination system located in Hamilton County was funded by the PEW Foundation through the living at home grant program. It consists of a computer network with enhances the case management system and also provides a daily updated, centrally located information system that both clients and agencies can easily access for better service provision.

The entry point of the living at home care coordination system is the information and referral system used at the Council on Aging of the Cincinnati Area, which is also the area agency on aging.

There are 19 satellite points, community social service agencies, that are connected via telecommunications to this I&R system. These satellite sites, along with the main entry point, have access to an information bank and can make referrals to one another. This system, by nature of design, ensures follow-up and coordination.

For example, when an older adult needs information, he or she might call the COA entry plant, or they might call their local community service provider. Frustration, anger, and loss of desire to pursue their initial request may result if the potential client is told to call still another number for help.

Referrals also can be made by family members, hospitals, professionals, or friends. It is estimated that 75 percent of I&R calls can be satisfied for giving out information; the other 25 percent need follow-up or assessment for further assistance.

The system works as follows:

Only clients who have been assessed and are receiving long-term care services are entered into the system by a member provider agency. All member provider agencies can assess the client information—name, address, Social Security number—to ascertain if any member agencies are already involved in the client.

A universal agreement procedure which is used by all provider agencies was developed to determine a client's eligibility to receive service. The development of this assessment was a major feat, in itself. Initially, when we designed this assessment, we discovered that half of the agencies involved in Hamilton County had no assessment. They used what we like to refer to as the "good old boy" process where somebody calls up, you have an initial discussion, and you sign the individual up for service. To get the agencies to agree to use one assessment was a major feat.

A person is considered eligible if he or she meets the following criteria: is unable to perform one or more of the activities of daily living without assistance—due to physical, cognitive, emotional, psychological, or social impairment—as listed: ambulation, bathing, dressing or undressing, eating, grooming, toileting, transferring, and medication management.

When an individual is eligible, the service package may include a variety, depending on availability, which may include homemaker/home health, respite, home-delivered meals, transportation, outreach, adult day care, and case management.

An agency serving an individual inputs their client's assessment into the computer and updates it every 6 months to adjust the care plan. Another agency receiving a call for service from the same client is being served by other agencies in Hamilton County.

The agency checking the computer does not have access to the client's assessment, but is able to obtain enough information to determine what other agencies are involved and what services are being performed. The system's design prevents duplication of services and promotes coordination of services in times of scarce resources.

Scenarios illustrating how the system works are:

Scenario one: A prospective client calls one of the 19 community satellite points for assistance. The information requested can easily be obtained through the program. The prospective client receives the information and does not want to be referred to a service provider.

The second scenario: A prospective client calls the I&R number and agrees to permit his or her name and request to be put into the system to be transferred to an agency that is determined best to manage the request. The agency chosen to receive the request checks the system, records the request information, and signals the referring agency that it has received the request.

The agency received the referral first checks the LAH care coordination system to see if the prospective client is being served by any other agency and what services are being provided. An assessment is done to determine eligibility using the universal assessment form. If eligibility is determined, a care plan is developed. Should another agency be providing assistance, the care plan developer coordinates service with the provider agency, which avoids costly duplication.

Clients can access the system through the main I&R or through the 19 affiliate agencies. This program has been operating for 3 years. There are currently 8,000 people entered into the system, meaning that there are 8,000 people who have assessments and other providers can access the system to find out who is serving these individuals.

Information is stored on a Micro VAX computer located at the Council on Aging. Each of the 19 affiliate agencies is connected to the system via telecommunication using modems. After initial development and equipment purchase, the only other expense is the cost of the phone lines and maintenance contracts.

Our next step will be to link hospitals into the system for a monthly service charge. This fee would eventually defray most of the operating costs.

The objectives of the program are: one, to provide updated information to client and service provides; two, to coordinate scarce resources; three, to provide a system that will enable all agencies to use the same assessment tool; and four, to obtain the available information for planning purposes.

This system recognizes the one-point entry system but allows clients to access their community agencies for assistance.

Our recommendations are: that all I&R systems funded with Older Americans Act money have a system set up for follow-up on emergency referrals; two, additional money be provided to help set up such a system; three, assessments be required on clients before long-term care services are provided.

I brought along the program manager, Nancy Perszyk. She handles the day-to-day operations. If there are questions afterwards, I'm sure she knows a lot more than I do.

[Prepared statement of Robert Logan, Executive Director, Council on Aging in Cincinnati, Inc., Cincinnati, OH follows:]

COMPUTERIZED CARE COORDINATION SYSTEM
COUNCIL ON AGING OF THE CINCINNATI AREA, INC.

ROBERT D. LOGAN, EXECUTIVE DIRECTOR
NANCY PERSZYK, ASSISTANT DIRECTOR/PROGRAMS

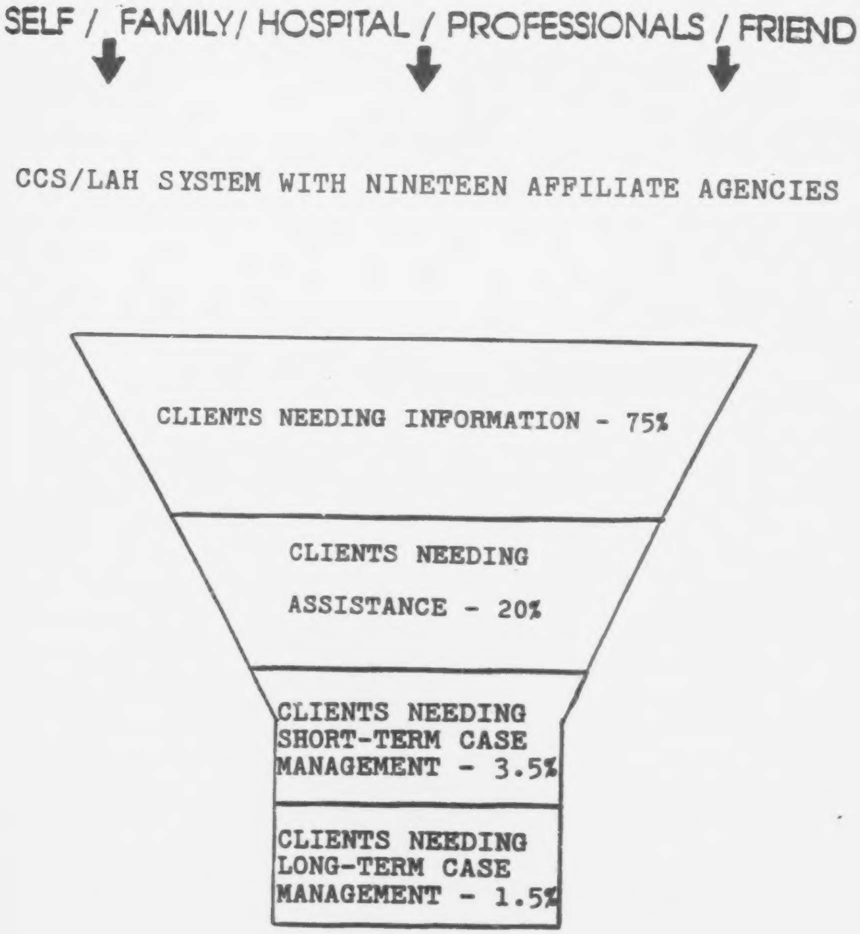
In all major metropolitan areas, there exist systems which are designed to serve the at risk elderly. These systems often are not well coordinated, are cumbersome to access, and at times generate duplication of service.

To maximize efficient use of limited private and public funding for long-term care, it is necessary to carefully screen individuals seeking assistance. Clearly, elders' needs and requests for assistance will vary in intensity, immediacy, and potential costs. Most clients need only accurate information; some need assistance with contacting service providers; and others need a comprehensive package of services. The more impaired the elder, the more likely he/she is to require a more extensive service response.

Thus, the Living-at-Home/Care Coordination (LAH/CCS) system operates on the principle of one-stop shopping. It is an easily accessible system set in place to supply information, assistance as needed, and referral to case management for clients with more complex needs, particularly those with deficits in functioning and informal supports.

The (LAH/CCS) located in Hamilton County was funded by the Pew Foundation through the Living-at-Home (LAH) program. It consists of a computer network which enhances the case management system and also provides a daily updated centrally located information system that both client and agency can access for better service provision.

The entry point of the LAH/CCS is the Information and Referral (I&R) system used by the Council on Aging of the Cincinnati Area, Inc. (COA). There are 19 satellite points (community social service agencies) that are connected via telecommunication to the I&R system. These satellite sites, along with the main entry point, have access to an information bank and can make referrals to one another. This system, by nature of its design, ensures follow-up and coordination. For example, when an older adult needs information, he/she might call the COA entry point or they might call their local community service provider. Frustration, anger, and loss of desire to pursue their initial request may result if the potential client is told to call still another number for help. Referrals also can be made by family members, hospitals, professionals, or friends. It is estimated that 75% of I&R calls can be satisfied by giving out information; the other 25% need follow-up or assessment for further assistance.


SELF / FAMILY/ HOSPITAL / PROFESSIONALS / FRIEND
CCS/LAH SYSTEM WITH NINETEEN AFFILIATE AGENCIES
CLIENTS NEEDING INFORMATION - 75%
CLIENTS NEEDING ASSISTANCE - 20%
CLIENTS NEEDING SHORT-TERM CASE MANAGEMENT - 3.5%
CLIENTS NEEDING LONG-TERM CASE MANAGEMENT - 1.5%

The system works as follows: Only clients whc have been assessed and are receiving long-term care services are entered into the system by a member provider agency. All member provider agencies can access the client information (name, address, Social Security number), to ascertain if other member agencies are already serving the individual. A universal assessment procedure which is used by all provider agencies was developed to determine the clients' eligibility to receive services (see enclosed).

A person is considered eligible if he/she meets the following criteria: is unable to perform one or more of the activities of daily living without assistance (due to physical, cognitive, emotional, psychological, or social impairment) as listed below:

- ambulation
- bathing
- dressing or undressing
- eating
- grooming
- toileting
- transferring
- medication management

When an individual is determined eligible, the service package may include a variety of services (depending on availability), which may include homemaker/home health aide, respite, home delivered meals, transportation, outreach, adult day care, and case management.

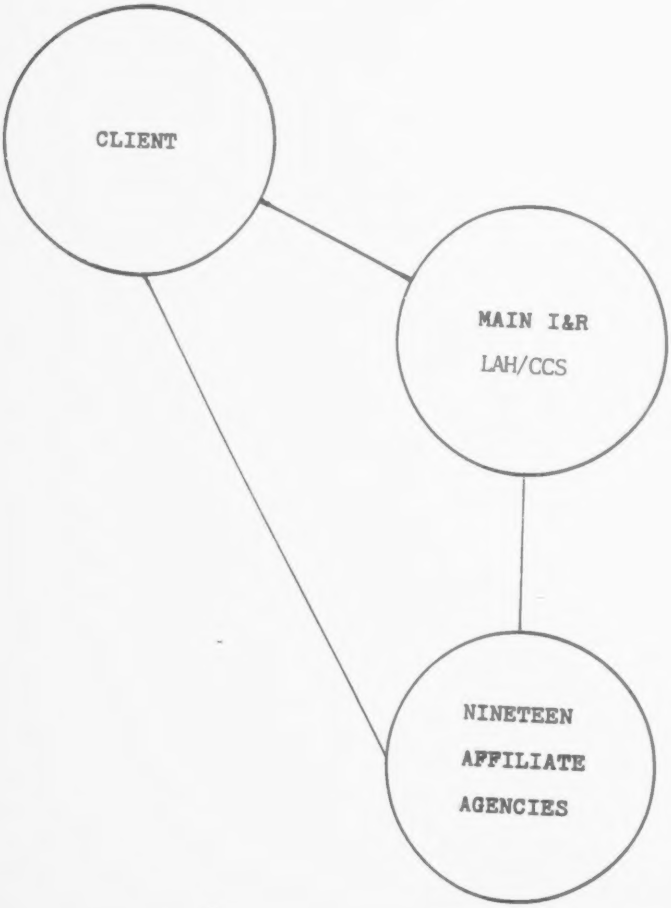
An agency serving an individual inputs their clients' assessment into the computer and updates it every six months to adjust the care plan. Another agency receiving a call for service from this same client first checks the computer to see if this client is being served by other agencies in Hamilton County, Ohio. The agency checking the computer does not have access to the client's assessment, but is able to obtain enough information to determine what other agencies are involved and what services are being performed. The system's design prevents duplication of services and promotes coordination of services in times of scarce resources.

Scenarios illustrating how the system works are:

Scenario I - A prospective client (PC) calls one of 19 community satellite points for assistance. The information requested can be easily obtained through the program. The PC receives the information and does not want to be referred to a service provider.

Scenario II - A PC calls the I&R number and agrees to permit his/her phone number and request to be put into the LAH/CCS system to be transferred to the agency that is determined best to manage the request. The agency chosen to receive the request checks the system, records the request information, and signals the referring agency that it received the request. The agency receiving the referral first checks the LAH/CSS system to see if the PC is being served by any other agencies and what services are being provided. An assessment is done to determine eligibility using the universal assessment form. If eligibility is determined, a care plan is developed. Should another agency also be providing assistance, the care plan developer coordinates services with the provider agency which avoids costly duplication.

Clients can access the system through the main I&R or one of the nineteen affiliate agencies.



Information is stored on a Micro VAX computer located at the COA. Each of the 19 affiliate agencies is connected to the system via telecommunication using modems. After initial development and equipment purchase, the only other expense is the cost of phone lines and maintenance contracts.

Our next step will be to link hospitals into the system for a monthly service charge. This fee would eventually defray most of the operating costs.

The objectives of this program are:

1. To provide updated information to client and service provider.

2. To coordinate scarce resources.

3. To provide a system that will enable all agencies to use the same assessment tool.

4. To obtain all the available information for planning purposes.

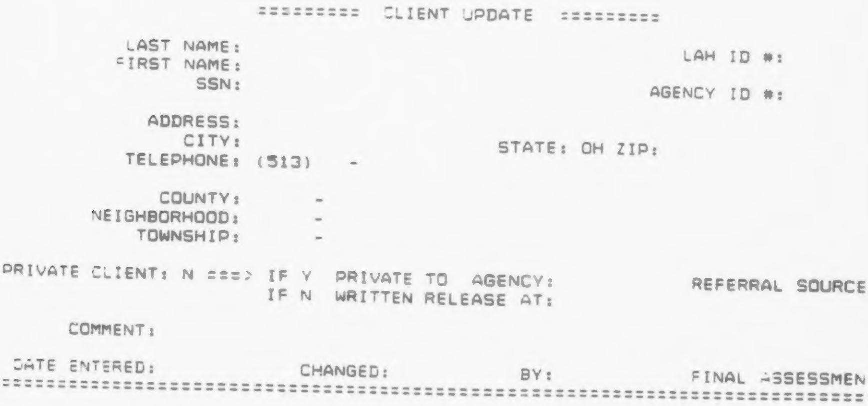
This system recognizes the one-point entry system but allows clients to access their community agencies for assistance.

RECOMMENDATIONS:

I. That all I&R systems funded with OAA monies have a system set up to follow-up on emergency referrals.

II. That additional money be provided to help set up such a system.

III. That assessments be required on clients before long-term care services are provided.



```
                    =========  CLIENT UPDATE  =========

          LAST NAME:
         FIRST NAME:                                          LAH ID #:
                SSN:
                                                           AGENCY ID #:
            ADDRESS:
               CITY:                         STATE: OH ZIP:
          TELEPHONE: (513)    -

             COUNTY:        -
       NEIGHBORHOOD:        -
           TOWNSHIP:        -

PRIVATE CLIENT: N ===> IF Y  PRIVATE TO  AGENCY:            REFERRAL SOURCE
                       IF N  WRITTEN RELEASE AT:

     COMMENT:

DATE ENTERED:             CHANGED:              BY:           FINAL ASSESSMEN
==============================================================================
                         ===  CLIENT UPDATE  ===
  ID          LAST NAM                                    FRST NAM
-------------------------------------------------------------------------------
  SEX (M,F)     BIRTH DATE          LITERATE (Y,N)      # LIVING CHILDREN
-------------------------------------------------------------------------------
 LANGUAGES SPOKEN     !    RACIAL AND                     !   EMPLOYMENT STATU
(OTHER THAN ENGLISH)  !    ETHNIC BACKGROUNDS:            !
                      !                                   !  1 = EMPLOYED
----------------------!  1 = AMER INDIAN,ALASKAN NAT      !  2 = SEEKING EMPLOY
  MARITAL STATUS:     !  2 = ASIAN,PACIFIC ISLANDER       !  3 = RETIRED
                      !  3 = BLACK (NOT HISPANIC)         !  4 = OTH (SPECIFY B
     1 = MARRIED      !  4 = HISPANIC                     !
     2 = WIDOWED      !  5 = WHITE (NOT HISPANIC)         !   COMMENTS
     3 = SINGLE       !  6 = OTHER (SPECIFY BELOW)        !
     4 = SEPARATED    !                                   !
     5 = DIVORCED     !   COMMENTS                        !   FORMER OCCUPATION
     6 = UNKNOWN      !                                   !
-------------------------------------------------------------------------------
                                  HEALTH CARE COVERAGE
 MEDICARE                     MEDICAID                     OTHER INS
```

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                      ========   CLIENT UPDATE   ========
 ID #         LAST NAM                               FRST NAM
-------------------------------------------------------------------------------

       HOUSEHOLD INCOME LEVEL:                 USUAL LIVING ARRANGEMENT (ENTER Y
       =========================               =================================
          1 = $0 - $4,999                         HOME/APARTMENT ===========>
          2 = $5,000 - $9,999                     RENTED ROOM(S) ===========>
          3 = $10,000 - $14,999                   LIVES ALONE  =============>
          4 = $15,000 - $24,999
          5 = $25,000 +                           LIVES WITH

                                                  CARETAKER

      TRANSPORTATION   (ENTER Y/N)                OTHER
 ================================
            OWNS CAR/CAN DRIVE ====>
                  CAN RIDE BUS ====>
 NEEDS HELP ON/OFF VEHICLES ===>
 NO MEANS OF TRANSPORTATION ===>
```

```
                      ========   CLIENT UPDATE   ========
 ID #         LAST NAM                               FRST NAM
-------------------------------------------------------------------------------
 HEARING/SIGHT (ENTER Y/N)                 MOBILITY       (ENTER 1,2,3,4,5)
 ========================                  =============================
  HEARING IMPAIRED ==>                                 1. BY SELF
  USES TELEPHONE ====>                WALKING ======>  2. MECHANICAL AID
  VISUALLY IMPAIRED =>                WHEELING =====>  3. MECH. AID & HUMA
                                      STAIRCLIMBING >  4. NEEDS HUMAN HELP
                                                       5. DOES NOT DO

 SPECIAL DIET (ENTER Y/N)              ACTIVITIES OF DAILY LIVING  (ENTER 1,2
 ======================               ======================================
  DIABETIC =========>                 1-BY SELF    2-NEEDS HELP    3-DOES NOT
  LOW SODIUM ========>
  LOW FAT ==========>                 BATHING =======>       LAUNDRY =========
  LOW CHOLESTEROL ==>                 GROOMING ======>       CHORE SERVICE ===
  SOFT =============>                 DRESSING ======>       SHOPPING ========
  OTHER ============>                 EATING/FEEDING >       MANAGING LEGAL/
  IF OTHER, SPECIFY BELOW:            TRANSFERRING ==>       FINANCIAL AFFAIRS
                                      CONTINENCE ====>       MEDICATION ======
                                      HOUSEKEEPING ==>       MEAL PREPARATION
```

```
              ========  CLIENT UPDATE   ========
ID #       LAST NAM                         FRST NAM
--------------------------------------------------------------------------------

                   EMERGENCY CONTACT INFORMATION
                   =============================
 NAME                          ADDRESS

 CITY                                STATE OH   ZIP CODE

 TELEPHONE NUMBER (513)          RELATIONSHIP TO CLIENT
--------------------------------------------------------------------------------

                   EMERGENCY PHYSICIAN INFORMATION
                   ===============================
 NAME                          ADDRESS

 CITY                                STATE OH   ZIP CODE

 TELEPHONE NUMBER (513)   -              DATE OF LAST VISIT
```

```
              ======== CLIENT UPDATE ========
ID #       LAST NAM                         FRST NAM
--------------------------------------------------------------------------------

                      OTHER PERTINENT FACTS
                      =====================

  CHURCH/ SYNAGOGUE AFFILIATION

  OTHER RELEVANT HEALTH FACTORS 1

  OTHER RELEVANT HEALTH FACTORS 2

  OTHER SUPPORT SYSTEM 1

  OTHER SUPPORT SYSTEM 2

   ADDITIONAL COMMENTS 1

   ADDITIONAL COMMENTS 2
```

Mr. SOLOMON. Thank you, Bob.

Our fourth presenter for the first panel is Mr. Richard Sugiyama. He is the Director of the Case Management Program of the Seattle-King County Division of Aging. Mr. Sugiyama comes to us from Washington with an extensive background in public service, with particular emphasis in aging issues. He holds a master's degree in social work from the University of Washington. Since 1984 he has been Director of the Case Management Program, an innovative program that, under his direction, has made a successful transition from an outreach program serving well-functioning seniors to a case management model serving only the most frail elderly.

Dick.

STATEMENT OF RICHARD SUGIYAMA, DIRECTOR OF CASE MANAGEMENT, SEATTLE-KING COUNTY DIVISION ON AGING, SEATTLE, WA

Mr. SUGIYAMA. Thank you very much, Jim.

Jim, I want to thank you first for the original introduction where you had me as having an honorary doctorate.

Mr. SOLOMON. Well, you deserve it.

Mr. SUGIYAMA. I assumed that was a creative typographical error.

Secondly, I want to thank the GAO and the Senate Special Committee on Aging for inviting me to speak today in support of the reauthorization of the Older Americans Act.

Before I begin my description of the Seattle-King County version of I&A, let me just share some characteristics of the county AAA.

First of all, in King County we are one of 13 Area Agencies on Aging in the State of Washington. Basically, each one of the 13 Area Agencies on Aging provide relatively the same format of I&A and case management services in a coordinated system.

We serve a county that has a total population of 1.3 million individuals, of which at least 16 percent of these people are 60 years or older. Within this group we have a very diverse elderly population. The minority population represents about 10 percent of the over-60 group. Within that elderly minority population we have extensive numbers of blacks, Native Americans, Latinos, and many subgroups of Asian/Pacific Islander elderly.

These are some of the county characteristics that have influenced the system that I am about to describe.

The written testimony that I am presenting will be available outside after 10:30 when it gets express mailed from Seattle.

In our State, the I&A system is intimately tied to the case management services that we provide. In many ways it was through the development of the case management services, policies, and standards by both the State and local levels that shaped our coordinated I&A system as it exists today.

The I&A system in King County was funded and formally implemented in 1984. We describe our system as a single intake system, but with multiple points of entry to provide access for our diverse client population.

Its overall function, as we have heard form other panelists, is to provide telephone information to callers, to provide assistance by phone for those persons who can't access services themselves, and most importantly, to screen those clients who are requiring a more intensive, in-home assessment by case management.

Our I&A system consists of five separate subcontracted agency providers in King County. First of all, we have one primary information and assistance program. They handle approximately 200 calls a day. This provider agency also handles walk-in clients with two out-station workers at a downtown agency.

The primary information and assistance agency provides services mainly to English-speaking persons in the county, with some limited capacity for Spanish and Japanese elderly access.

Most importantly to our system is that we also have four subcontracted special I&A providers. These agencies, we feel, lessen the barriers of language, culture, and geographic isolation for our communities. The four providers are Asian Counseling and Referral Services, Chinese Information and Service Center, Sea-Mar Community Health Center's Latino I&A Program, and, finally, a Seattle Housing Authority Neighborhood House program that serves five distinct, low-income, subsidized housing communities. All of these programs provide countywide services.

Together, these five I&A programs have the capability of servicing and responding in 23 different languages and dialects. In 1989, they provided approximately 66,000 information-giving contacts, as well as providing phone and in-person assistance to another 6,700 individuals. Persons entering the system through any of these five agencies then gain access to the wide array of community aging services.

For some individuals coming through the I&A agencies, far more extensive intervention is needed. These individuals—which numbered about a little less than 3,000 last year—are screened and then referred. Within 3 working days a case manager is in the clients home doing an in-person comprehensive assessment.

In our State, the definition that we use for case management level services are for people who are eligible for a COPES type nursing home diversion program, or if the client is an elder abuse victim, or if the individual has multiple service needs as a result of their functional deficits.

In King County the case management component consists of actually three programs—one large one, of which I am the director, and two smaller programs serving separate geographic areas in the State.

Once a client is referred to our agency, we provide a comprehensive assessment, followed by an individualized written service plan of care. We provide the care coordination of those services that have been identified and we provide monthly monitoring. And for the first year, we perform four in-home reassessment visits with the client and their family. We average about 8.5 months of involvement for our clients before we begin our termination planning.

Some unique aspects of our particular I&A and case management program include the fact that we think we have a highly successful program that addresses cultural diversity, language barriers, and geographical barriers. Our system has served significant number of minorities. Of all the persons receiving I&A services last year, 42 percent were minority persons. Minority persons represented 22 percent of all the persons receiving case management services.

Second, we feel that this system emphasizes a range of different service levels within the I&A system.

Third, we think that the system, because it is a freestanding I&A system separate from any other service provision, gives us the added edge of a greater objectivity when planning the plan of care and also offers far more individualized choice of services by the client.

Additional unique factors are that this system supports existing minority community service providers. The system also emphasizes a strong gatekeeper training component. One of the nicest parts of this system is that with all five I&A, and three case management programs being funded by the AAA and monitored by one person, we have evolved into a standardized system.

There are about six factors that have contributed to our success that I'd like to just briefly touch on.

One of the reasons I think we were able to get a system like this up and going in King County is that there was an earlier system that evolved from the congregate nutrition sites. In the mid-1970's one of the aging programs hired nutrition outreach workers, who then evolved into more generalist types of outreach workers. And then, as that evolved, it turned into a phone-based information agency.

Second, in our State and our AAA there was developing in the early 1980's a targeting policy that focused on the most vulnerable or at-risk persons in our community, and some of those targeting criteria involved persons being 75 years or older living alone, or having non-English-speaking, or were low income, or minority.

Third, in 1983 the AAA developed a case management program policy that emphasized a coordinated information and assistance and case management system, and implemented that in 1984.

Some other points include the fact that the State recognized the added difficulty in providing services to minorities and other vulnerable categories of elderly. The State Unit on Aging created a weighted formula in which they allocated an additional portion of their aging funds to AAAs based on the targeting characteristics that I mentioned.

The AAA also, in our county, increasingly set higher expectations for the services to minority groups. Because we found a high correlation of poverty related to being of minority status, the AAA took it upon themselves to begin first with about a 10 percent target expectation, and increased it to 15 percent and currently up to 20 percent right now.

Another factor that helped our system get established was the fact that in our community we already had preexisting minority communities with which to subcontract. Also, we were fortunate enough to have established a partnership with the community in securing community development block grants for Chinese Information Services, and also we had a successful 3-year demonstration project with the Administration on Aging to provide services to Indo-Chinese elderly in King County.

In closing, my final remarks concern a few recommendations to improve the I&A system.

First of all, the King County AAA recommends that we revise the language in the Older Americans Act to state that it would "allow" AAAs to provide information and referral and case management services without having to seek a waiver from the State.

Second, our AAA supports the creation of coordinated I&A and case management services as a regular component of ongoing services for all States.

In closing, I want to thank you again for the opportunity to share this information with you in support of the Older Americans Act.

[The prepared statement of Mr. Sugiyama follows:]

TESTIMONY BEFORE SENATE SELECT COMMITTEE ON AGING
WORKSHOP ON THE REAUTHORIZATION OF THE OLDER AMERICANS ACT OF 1965

PRESENTED BY:

DICK SUGIYAMA
SEATTLE-KING COUNTY AREA AGENCY ON AGING
DIRECTOR, CASE MANAGEMENT PROGRAM

Thank you for the opportunity to both speak before the Committee and other interested parties, plus the chance to hear the other panelists describe their service delivery models for information, referral and assistance.

Seattle-King County Area Agency on Aging

Before I begin my description of the Seattle-King County Information and Assistance/Case Management system, I want to describe some key characteristics of King County. First, we are one of 13 Area Agencies on Aging (AAAs) in the state of Washington. King County has a population of 1.3 million, of which 16%, or 217,000 persons, are 60 years of age or older. This group of 60+ year olds had traditionally been located in Seattle, but a gradual shift over the years has resulted in a city/county ratio of 50/50 expected in 1990.

Within this 60+ year old population, we find an overall non-White, minority elderly population of close to 10% (or 20,908 persons). We have a very diverse elderly population of White, Black, Native American, Latino and Asian/Pacific Islander elderly, so you can see some of the demographic factors that have influenced the system I am about to describe.

1. I&A/CM System

   The Information and Assistance system in Seattle-King County cannot be discussed without including case management services because, in many ways, it was the development of Case Management policies and standards at both the State and local levels that shaped the I&A system.
   The I&A system in King County was formally implemented in 1984, and can be described as a single intake system, with multiple points of entry to provide access for our diverse client population. It's overall purpose is to provide telephone information to callers, assist by phone, and to screen for those clients requiring an income assessment by a case manager.

   This system has one primary Information and Assistance provider agency, with phone advocates who handle phone calls countywide. These advocates provide information, referral and phone assistance, when necessary. This primary I&A agency handles approximately 200 calls per day, or 45,000 calls per year. In addition, this provider handles walk-in clients with two full-time staff workers outstationed at a busy central downtown Seattle location which provides services to the elderly. Services are provided to English, Spanish and Japanese speaking individuals.

Special I&A

Most importantly, this system also includes four Special I&A providers to lessen the barriers of language, culture and geographic location. These four providers are the Asian Counseling and Referral Service, the Chinese Information and Service Center, the Sea-Mar Community Health Center's Latino Elderly I&A Program, plus the Seattle Housing Authority's Neighborhood House Elderly I&A Program. All four of these programs provide countywide services.

Together, these five I&A programs provide services in 23 different languages and dialects. In 1989, they provided 65,875 information contacts and provided phone and in-person assistance to another 6,700 individuals. Customers are able to enter the system through one agency, and gain access to a wide array of services available in the community (for example, home-delivered meals, housing options, home care, health/mental health care, entitlements, respite, senior center information, discounts for seniors, and the list goes on.)

Now, if you can envision this system as looking like a large, multi-panelled hot air balloon, with the center panel being the largest one, and four smaller panels on the balloon, you've gotten a picture of our system.

Case Management Services

Then, of course, below the hot air balloon, is the wicker basket, which I would characterize as the Case Management services component. This higher level of intervention is provided to about 4.2% (2,900 clients) of all the callers who come through the I&A/Special I&A system.

The definition of a Case Management client is one who is eligible for either the COPES program, is an abuse victim, or has multiple service needs with little or no supports to assist them in accessing services. In King County, this Case Management component is made up of one large Case Management program, and two smaller programs serving separate geographic areas in the county. One of these two programs is part of a hospital district that subcontracts to provide case management for the eastern part of our county.

Until recently, all special I&As, in addition to the primary I&A, referred Case Management level clients to our program for Case Management services. Now, two special I&As provide Case Management level services as well.

Case Management services, at least in Washington, must include five core functions. These are:

1) in-home comprehensive assessments;
2) written individualized plans of care;
3) implementation/coordination of the service plan;
4) ongoing monthly monitoring and at least four in-home reassessment visits during the fist year; and
5) client termination planning.

2. Unique Aspects of Program

Some of the unique aspects of our I&A/CM system include:

a. A system that recognizes cultural diversity, language barriers and geographical barriers, and addresses them with culturally relevant services. This system serves individuals who speak 23 different languages/dialects with a bicultural staff, and also serves low-income housing communities and outlying island communities.

b. This is a system which emphasizes a range of service levels (information only, phone assistance, in-person assistance, case management) and focuses on the least restrictive care options, along with client choice.

c. This system is a free standing I&A/CM system, which we feel provides a greater degree of objectivity and opportunity for client choice.

d. This system supports minority community organizations which we feel are best able to provide culturally relevant services. (Twenty-four percent of all AAA dollars go to minority agencies.)

e. This system also emphasizes a strong gatekeeper training component to inform community and local service providers about warning signs for identifying at risk elders living in the community.

f. And, finally, since all of the I&A and special I&A programs are funded by the AAA and monitored by one person, a standard system of forms, service referral and data collection has been established.

3. Factors Contributing to Success

I found it fascinating to look back at how this system was created and how it evolved, since a number of critical decisions had been made prior to my arrival in 1984.

a. An earlier system from the mid-1970's was in place that was built around nutrition outreach workers -----> information and referral outreach workers -----> phone-based I&A.

b. The State and the local AAA developed a targeting policy that focused on providing the State's declining resources to those "most vulnerable or at risk of premature institutionalization" (e.g., 75+ years of age, isolated, non-English speaking, low-income, minority). This meant moving our staff out of the senior centers to begin serving the less functioning adults who were unable to attend these centers.

c. In 1983, the AAA developed a Case Management program policy which emphasized a coordinated I&A/CM system, and implemented it in 1984. This followed the State's direction toward a long term care system that was a social model, rather than an acute care, medical model. Case managers became the primary coordination point for ensuring that vulnerable adults receive the appropriate level of service.

d. The State developed a weighted formula which allocated a part of the aging funding to serve areas based on the targeting characteristics.

e. The AAA set higher expectations for service goals to minorities because of their high correlation to poverty (from 9.2% to 15% -----> 20% standards).

f. The pre-existence of minority agencies with whom to subcontract, such as the Asian Counseling and Referral Service (mental health), Chinese Information and Service Center and Neighborhood House.

g. Plus the Pacific-Asian Elderly Project's Administration on Aging grant in early 1980 which funded bilingual elder I&A staff for Indo-Chinese elderly and other Pacific Islander elderly.

In addition, I am sure there were several other factors that contributed to the system's development.

4. Legislative Steps to Improve Information and Referral Delivery

My final remarks concern recommendations on improving the I&A system. The King County AAA recommends revising the language of the Older Americans Act to "allow" AAAs to provide Information and Referral and Information and Assistance services, to avoid having each AAA seek a waiver if it wanted to provide such services in-house.

Secondly, at the State level, our AAA supports the creation of coordinated I&A and case management services as a regular component of its ongoing services.

In closing, I would like to thank you again for the opportunity to share this information with all of you in support of the reauthorization of the Older Americans Act. Thank you.

Norman B. Rice, Mayor
Mayor of Seattle

Tim Hill, County Executive
King County

Bruce M. Pym
Chairman of the Board
United Way of King County

Seattle-King County
Division on Aging

INFORMATION AND ASSISTANCE/ CASE MANAGEMENT SERVICES SYSTEM

BACKGROUND

The Information and Assistance/Case Management single entry system was designed by several task forces in 1983 as a result of the planning efforts of many State and local committees in order to follow the new Washington State Case Management policies. Prior to this time, outreach and limited case management services were provided by several community-based programs. There was little attention given to a coordinated system design.

In 1984, when the new system was implemented, the following principles were followed by the Seattle-King County Division on Aging:

1. Case management services will be provided by a single long term care organization within a designated geographic area. This agency should preferably be a locally managed organization.

2. A primary telephone-based provider of information and assistance will be the main entry and screening point for clients requesting or needing information and assistance/case management (I&A/CM) services.

3. Special information and assistance programs will be designated to provide I&A service to elderly clients who cannot access the primary information and assistance provider because of language, cultural or geographical barriers.

Many minority individuals do enter the case management system through the main entry point by a referral from the Senior Information and Assistance Program. Currently, those who manage English or speak Spanish or Japanese can be served through the main telephone system which is based at Senior Services and Centers, a nonprofit agency and a major provider of service to elderly clients in King County.

A case management service provided by the Evergreen Care Network was included in the system during 1985. The geographically specific program offered the Division on Aging an opportunity to be involved in a managed long term care model.

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Administered by the City of Seattle, Department of Human Resources, Jerry L. Agen, Acting Director
This program complies with all federal, state and local non-discrimination laws
A Cooperative Program of: City of Seattle, King County, and United Way of King County

SYSTEM DESCRIPTION

I. INFORMATION AND ASSISTANCE PROGRAMS/CASE MANAGEMENT SYSTEM

A. Primary Information and Assistance

Primary information and assistance provides telephone-based services designed to locate and identify older persons who need service(s) and link them with appropriate resource(s). Staff are located in a central office and at the Mayor's Office for Senior Citizens (MOSC). The two advocates stationed at MOSC also assist clients on a walk-in or office appointment basis. Services include information giving, service referral or assistance in obtaining a needed service when the client is unable to perform these activities and has no one who can or will perform them. Direct intervention between a client and an agency is provided when agencies are either unresponsive or services are inaccessible to a client. Clients are screened to determine whether an older person should be referred to the Division on Aging Case Management Program for a comprehensive assessment. The I&A/CM Program is responsible for I&A/CM publicity and for maintaining a file of community resources which serve older people.

B. Special Information and Assistance Programs

Special information and assistance programs provide services designed to identify and link with appropriate resources elderly minority persons who are not able to access an adequate level of I&A services through primary information and assistance because of a language or racial barrier. Staff are located in five agencies which serve the Asian, Filipino, Black and Latino communities. Services are provided by bilingual staff via telephone, office and home visits, and include information giving, service referral or assistance in obtaining a needed service when the client is unable to perform these activities and has no one who can or will perform them. Direct intervention between a client and an agency is provided when agencies are either unresponsive or services are inaccessible to a client. Clients are screened to determine whether an older minority person should be referred to the Division on Aging Case Management Program for a comprehensive assessment.

The following agencies provide Special I&A:

- Chinese Information and Service Center
  Elderly I&A Services
  Telephone: (206) 624-4062

- Asian Counseling and Referral Service
  Elderly I&A Services
  Telephone: (206) 447-8486

- Neighborhood House (Seattle Housing Authority)
  Elderly I&A Services
  Telephone: (206) 447-8439

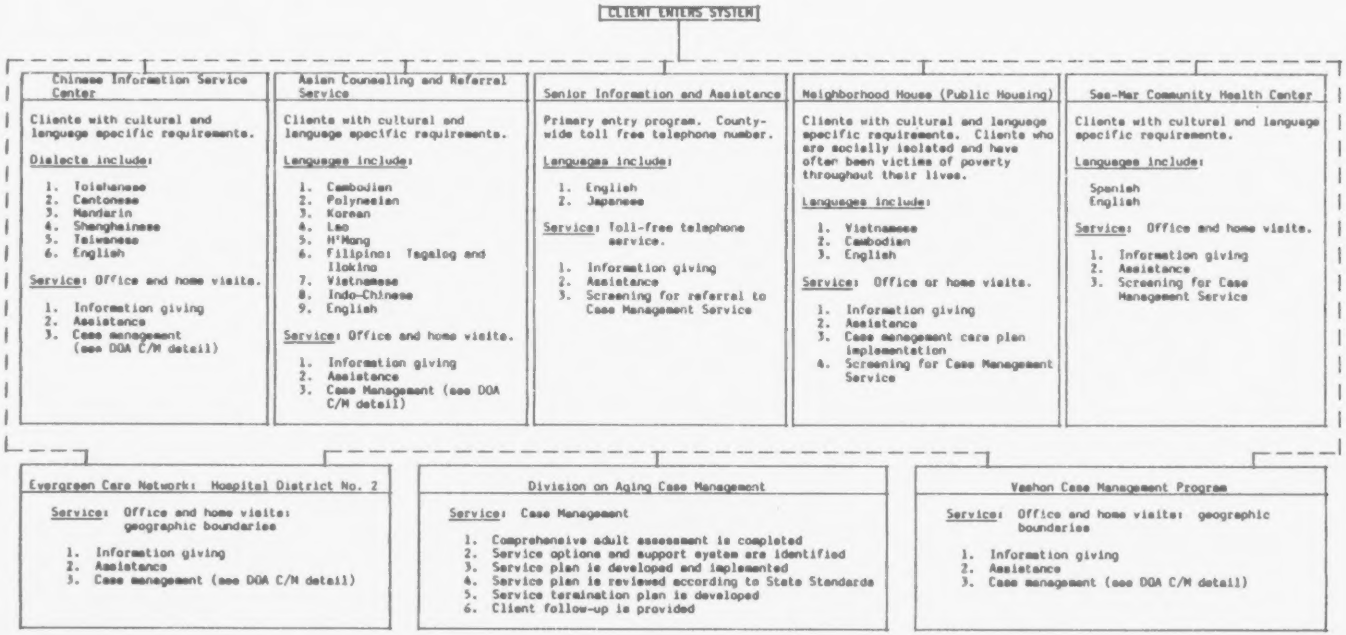
- Sea-Mar Community Health Center
  Latino Elderly I&A Services
  Telephone: (206) 764-4716

II. CASE MANAGEMENT PROGRAM

The Case Management Program provides assistance in obtaining necessary support services to certain functionally impaired adults. These services are designed to achieve and maintain the maximum level of health and independence of which the older person is capable, and to prevent or delay institutionalization. In addition to the Division on Aging Case Management Program's City and County offices, staff are located on Vashon Island to serve geographically isolated persons. Case management services are also provided to elderly persons living in Hospital District #2 through the Evergreen Care Network. Case management services include a comprehensive assessment, development of a detailed plan of service, service plan implementation, review, termination planning and records maintenance. The Program also provides case management services to persons who are authorized for COPES Case Management and abused/exploited elders. Screening for case management services is provided by the information and assistance programs.

Seattle-King County
Division on Aging

INFORMATION AND ASSISTANCE CASE MANAGEMENT SYSTEM



CLIENT ENTERS SYSTEM

Chinese Information Service Center

Clients with cultural and language specific requirements.

Dialects include:

1. Toishanese
2. Cantonese
3. Mandarin
4. Shanghainese
5. Taiwanese
6. English

Service: Office and home visits.

1. Information giving
2. Assistance
3. Case management (see DOA C/M detail)

Asian Counseling and Referral Service

Clients with cultural and language specific requirements.

Languages include:

1. Cambodian
2. Polynesian
3. Korean
4. Lao
5. H'Mong
6. Filipino: Tagalog and Ilokino
7. Vietnamese
8. Indo-Chinese
9. English

Service: Office and home visits.

1. Information giving
2. Assistance
3. Case Management (see DOA C/M detail)

Senior Information and Assistance

Primary entry program. County-wide toll free telephone number.

Languages include:

1. English
2. Japanese

Service: Toll-free telephone service.

1. Information giving
2. Assistance
3. Screening for referral to Case Management Service

Neighborhood House (Public Housing)

Clients with cultural and language specific requirements. Clients who are socially isolated and have often been victims of poverty throughout their lives.

Languages include:

1. Vietnamese
2. Cambodian
3. English

Service: Office or home visits.

1. Information giving
2. Assistance
3. Case management care plan implementation
4. Screening for Case Management Service

Sea-Mar Community Health Center

Clients with cultural and language specific requirements.

Languages include:

Spanish
English

Service: Office and home visits.

1. Information giving
2. Assistance
3. Screening for Case Management Service

Evergreen Care Network: Hospital District No. 2

Service: Office and home visits: geographic boundaries

1. Information giving
2. Assistance
3. Case management (see DOA C/M detail)

Division on Aging Case Management

Service: Case Management

1. Comprehensive adult assessment is completed
2. Service options and support system are identified
3. Service plan is developed and implemented
4. Service plan is reviewed according to State Standards
5. Service termination plan is developed
6. Client follow-up is provided

Vashon Case Management Program

Service: Office and home visits: geographic boundaries

1. Information giving
2. Assistance
3. Case management (see DOA C/M detail)

Norman B. Rice, Mayor
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King County

Bruce M. Pym
Chairman of the Board
United Way of King County

Seattle-King County Division on Aging

THE SEATTLE-KING COUNTY DIVISION ON AGING CASE MANAGEMENT PROGRAM

The Seattle-King County Division on Aging (SKDOA) Case Management Program (CMP) serves frail, older people who can no longer care for their own needs and do not have family or others who can assist them. Clients of the Program face many physical, mental and social problems. Because of these limitations, they experience frequent hospitalization and are at risk of being placed in nursing homes. The purpose of the Program, therefore, is to enable clients to remain at home in a safe and healthy environment, reducing "revolving door" hospitalizations, as well as preventing unnecessary or premature nursing home placement.

The Program addresses two major sets of factors that seriously affect the lives of older people. First, it recognizes the growing population of frail, chronically ill elderly. Chronic health problems affect an older person's ability to live independently and to carry out activities of daily living, such as walking, eating and dressing. These health conditions do not lend themselves to high-tech, cure-oriented approaches. Rather, they require ongoing support and care. With advanced age, chronic health problems are compounded by other losses. Clients often experience the loss of a spouse, relatives or friends who have provided care and support. Others may experience diminished mental capacity. In addition, legal and financial problems often arise from changes in health, life-style and income status.

Second, efforts have been made in recent years to control the rising costs of health and institutional care, while still meeting the needs of a growing population of frail elderly. Public policies have expanded to include some home and community-based services, such as home health, home-delivered meals, homemaker/chore services and day health programs. This system, however, has developed on a piecemeal basis and is characterized by a bewildering array of providers, fund sources, benefits and financial eligibility requirements. The frail older person most in need of these services is the least likely to know of or be able to independently arrange for such care. Thus, many individuals and their families, unaware of various community resources, view nursing home placement as their only alternative when care is needed.

The Case Management Program's highest priority is to serve frail, chronically ill older adults who: a) need nursing home level care, yet want to remain living at home; b) are victims of abuse, exploitation or neglect; or c) require multiple social and health services in order to remain at home. In addition, the Division on Aging has adopted its own targeting policy which emphasizes serving the most vulnerable, "at-risk" elderly, using the following characteristics as indicators of potential vulnerability: low-income; 75 years of age or older; homebound; racial or ethnic minority; non-English speaking; living alone; and geographically isolated.

There are 209,000 older people living in King County. We estimate that 4,200 are frail and in need of case management services. On an annual basis, we serve over 2,000 clients, therefore, we reach approximately 48% of the total eligible population.

To date, the Case Management Program is enabling over 5,000 clients who need nursing home level care to remain at home. Because of this accomplishment, the Program is considered to be both beneficial to the client, as well as an effective tool in the long term care system.

Clients are referred to the CMP through the Information and Assistance Program.* All calls for information, assistance and case management are made to one toll-free number serving the entire King County area. Referrals come from many sources (e.g., hospitals, police, home health agencies, family, neighbors, adults protective service workers, etc.). The calls are screened and those clients needing case management services are then forwarded to our program. Clients are contacted within 24 hours of the referral.

*Refer to the SKDOA Information and Assistance/Case Management System material on Special Information and Assistance programs.

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King County

Bruce M. Pym
Chairman of the Board
United Way of King County

Seattle-King County Division on Aging

INFORMATION AND ASSISTANCE CLIENTS SERVED
1989 SUMMARY

I.	Total New Clients	6,696
II.	Race/Ethnic Group	
	a. Chinese	673
	b. Japanese	36
	c. Filipino	214
	d. Indochinese	337
	e. Pacific Islander	62
	f. Korean	166
	g. Black	1,087
	h. Hispanic	191
	i. Native American Indian	24
	j. Alaska Native	14
	k. Caucasian	2,922
	l. Other groups not listed	33 (included in minority total)
	m. Unknown	937
	total % minority	42%
	total no. minority	2,837

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Administered by the City of Seattle, Department of Human Resources, Jerry L. Agen, Acting Director
This program complies with all federal, state and local non-discrimination laws
A Cooperative Program of: City of Seattle, King County, and United Way of King County

The case managers meet with the clients in their homes where the older person's functional skills and limitations are discussed and a comprehensive assessment is completed. Then, the case manager works with the client to develop a plan of care which often includes arranging for services such as home health, chore and home-delivered meals. Case managers also address more complex issues with clients such as alcohol or drug abuse, depression, suicide threats or family problems that affect the client's health and safety. The case manager continues to work with the client for an average of five to seven months, until the client's situation is stabilized and a "support system" such as family, friends, neighbors and/or service providers is established to meet the ongoing needs of the client.

Because of our work with clients, CMP staff often identify areas of need where few or no services exist. Therefore, we are involved in developing and coordinating new resources to meet client needs such as respite care, community options for jailed elderly, money management help and Alzheimer's support groups.

Our most recent efforts to develop and improve the case management system include: implementing quality assurance methods such as satisfaction surveys and an outcome evaluation; computerizing client data; and providing technical assistance to other agencies that are developing case management programs.

An important achievement is the agreement to provide case management services to Blue Cross Long Term Care Insurance enrollees. We believe that this commitment demonstrated by Blue Cross reflects a growing acknowledgement of the importance of case management services.

The SKDOA Case Management Program's strongest supporters include:

- Local Governing Bodies - City of Seattle, King County and United Way because we effectively address the needs of a growing "at-risk" population.

- Washington State - Aging and Adult Services Administration because the Program exemplifies the State's direction towards increased community-based care for the elderly and, in some areas (such as quality assurance and exceeding standards), the Program has taken a leadership role in the state.

- Local Service Providers - Harborview Medical Center, the Seattle Police Department, Catholic Community Services, Adult Protective Services and others because of our ability to work with clients who have complex and severe problems, and because we continue to work with the client until the situation has stabilized.

Norman B. Rice, Mayor
Mayor of Seattle

Tim Hill, County Executive
King County

Bruce M. Pym
Chairman of the Board
United Way of King County

Seattle-King County Division on Aging

CASE MANAGEMENT CLIENTS SERVED
1989 SUMMARY

I.	Total New Clients	2,866
II.	Race/Ethnic Group	
a.	Chinese	27
b.	Japanese	17
c.	Filipino	68
d.	Indochinese	164
e.	Pacific Islander	4
f.	Korean	42
g.	Black	257
h.	Hispanic	29
i.	Native American Indian	14
j.	Alaska Native	0
k.	Caucasian	2,224
l.	Other groups not listed	13 (included in minority total)
m.	Unknown	7

total % minority 22%

total no. minority 637

110 Prefontaine Pl. S. • Seattle, Washington 98104 • 206/684-0660
Administered by the City of Seattle, Department of Human Resources, Jerry L. Agen, Acting Director
This program complies with all federal, state and local non-discrimination laws
A Cooperative Program of: City of Seattle, King County, and United Way of King County

Mr. Solomon. Thank you, Dick.

I think each of the panel members in the first panel have provided us some very interesting thoughts about the program that will help us as we look at the reauthorization.

I am now honored to introduce a gentleman I'm sure doesn't need an introduction to most anyone here, but Senator Pryor has joined us.

Senator Pryor.

STATEMENT OF SENATOR DAVID PRYOR, CHAIRMAN

Senator Pryor. Jim, thank you. I'd like to thank you and the General Accounting Office for lending your services and the expertise of GAO in this very unique sort of a workshop atmosphere. We're trying to experiment in the Aging Committee with something that is different from a formalized hearing where we sit way up there and we have about four witnesses of a panel and we drone on for hours and hours without the audience participating. These workshops I think will be beneficial and constructive, but only if the audience participates. Notwithstanding the fact that we have a great wisdom and expertise at the table—excluding me—we also should certainly realize that a great deal of wisdom and expertise is equally out there in the audience. We want all of you to feel free to participate.

Jim, I would like to sort of dedicate this series of workshops, if I might take a personal moment, to the late Senator Sparky Matsunaga. It was in 1987 when the Older Americans Act authorization was reauthorized. It has now been authorized 10 times since 1964. It was Senator Matsunaga's lead and his great enthusiasm for this issue and for the protecting and giving life of dignity to the elderly. It was Sparky's real commitment to see that this Act was authorized and funded. I would like, if I might, because he was on the Labor Committee, he was the Chairman of the Aging Subcommittee on that Committee, Sparky Matsunaga—I think that we should dedicate this series of workshop hearings in his name.

We all know what the I&R subject is about. It is about how we can make that system better, how people out there in the elderly community, not only can rely, but, more importantly right now, have access. There are a lot of people—millions of people—who do not know the services that are available. I have found it not only in my own family experiences, but I have found it across the board that people just don't know.

Also I think, too, that the elderly person is somewhat reluctant to come forward and admit that they don't know where to find a particular service or fact or figure, and sometimes they are very hesitant and very shy. There is a great deal of pride involved, and they are hesitant to come forward and say, "I don't know where to find out about this service."

We think it is incumbent through the thrust of the Older Americans Act, that network that has been established throughout America by the Act—we think it is incumbent upon those of us in this issue involved and committed to it to take a more aggressive role in making certain that elderly Americans are aware of this information, the services that are available, and also that the data and information that we gather, which will be the subject for our second panel, will be that information that will be useful to the elderly person.

We all think that we can do a better job, and I hope today will signal sort of a recommitment to that.

I'd like to personally thank Bill Benson here on my right for helping on this and putting this together, and, of course, Portia and her staff and our friend John Monahan for involving himself, and especially a new addition to the permanent staff on the committee, Anna Kindermann and her great contribution. She has worked around the clock the last month in getting the witnesses here and making sure that everything is in order.

Jim Loftis, we would especially thank you for coming from Arkansas. I just got back from Arkansas yesterday, so we appreciate your being here, Jim, and sharing your thoughts.

So thank all of you and all of our panelists today, we are very grateful to you. I look forward to listening.

Thank you.

By the way, this is kind of off the record with our report, I've got a son running for the State Legislature, if you could imagine I'm that old. I can hardly believe it. But he announced it. He surprised all of us. He asked what he should do—he is trying to keep me out of his campaign. He said, "What should I do, Dad? What should I say to people?"I said, "Mark, it is not very important about what you say. It is pretty important what your constituents say. You go out there and just listen." That's why I am here today.

Thank you.

[The prepared statement of Senator Pryor follows:]

STATEMENT OF SENATOR DAVID PRYOR
SECOND OLDER AMERICANS ACT WORKSHOP
APRIL 19, 1990

THANK YOU VERY MUCH FOR ATTENDING THIS YEAR'S SECOND LEGISLATIVE WORKSHOP CONCERNING REAUTHORIZATION OF THE OLDER AMERICANS ACT.

TODAY IS A SAD DAY FOR ALL OF US WHO CARE ABOUT OUR NATION'S SENIOR CITIZENS. THE PASSING OF SPARK MATSUNAGA, THE DISTINGUISHED SENATOR FROM HAWAII AND CHAIRMAN OF THE AGING SUBCOMMITTEE OF THE LABOR COMMITTEE, IS A GREAT LOSS IN THE BATTLE TO ASSURE DIGNITY AND INDEPENDENCE FOR ELDERLY AMERICANS. JUST THREE YEARS AGO, HE SPEARHEADED THE DRIVE TO REAUTHORIZE THE OLDER AMERICANS ACT, AND WE WILL UNDOUBTEDLY MISS HIS WISDOM AND COUNSEL IN THIS REAUTHORIZATION CYCLE. IN HONOR OF HIS UNFAILING COMMITMENT TO THE VULNERABLE PERSONS SERVED BY THE OLDER AMERICANS ACT, I WISH TO DEDICATE THIS WORKSHOP SERIES TO THE MEMORY OF MY FRIEND SENATOR SPARK MATSUNAGA.

AS YOU KNOW, THIS WORKSHOP SERIES IS SPONSORED BY THE SPECIAL COMMITTEE ON AGING, IN COLLABORATION WITH THE GENERAL ACCOUNTING OFFICE. LET ME TAKE THIS OPPORTUNITY TO THANK GAO FOR ITS EXCELLENT WORK IN PREPARATION FOR TODAY'S WORKSHOP.

BEFORE TURNING TO TODAY'S AGENDA, LET ME MAKE A COUPLE POINTS ABOUT THE FORMAT OF THIS LEGISLATIVE WORKSHOP. I AM PROUD TO SAY THE AGING COMMITTEE HAS TAKEN THE LEAD IN EXPERIMENTING WITH ALTERNATIVES TO LEGISLATIVE HEARINGS. HEARINGS CAN SOMETIMES BE TOO FORMAL, AND CRITICAL GIVE-AND-TAKE BETWEEN INTERESTED PERSONS CAN BE STRAINED.

I HOPE TODAY'S WORKSHOP WILL BE INFORMAL, AND I URGE ALL MEMBERS OF THE AUDIENCE TO PARTICIPATE ACTIVELY. THE SUCCESS OF TODAY'S DISCUSSION DEPENDS UPON YOUR PARTICIPATION. THE PURPOSE OF THE WORKSHOP SERIES IS TO GIVE MEMBERS OF THE COMMITTEE AN OPPORTUNITY TO HEAR THE VIEWS OF PERSONS DIRECTLY INVOLVED IN DELIVERING SERVICES TO OLDER PERSONS, THAT IS, ALL OF YOU IN THE AUDIENCE.

LET ME NOW SAY A FEW WORDS ABOUT THE TOPICS TO BE DISCUSSED TODAY.

FIRST, I HOPE OUR OPENING PANELISTS WILL DRAW NEEDED ATTENTION TO THE IMPORTANCE OF INFORMATION AND REFERRAL SERVICES. INFORMATION AND REFERRAL ARE CENTRAL TO THE PURPOSE OF THE OLDER AMERICANS ACT, BUT OFTEN GET OVERSHADOWED BY OTHER SERVICES. AS I SEE IT, THE AGING NETWORK HAS NO MORE IMPORTANT MISSION THAN TO PROVIDE ELDERLY PERSONS AND THEIR CAREGIVERS A PLACE TO TURN TO FOR INFORMATION. UNTIL THEY NEED SERVICES FOR THEMSELVES OR THEIR LOVED ONES, MOST PEOPLE ARE UNAWARE OF HUMAN SERVICES PROGRAMS AVAILABLE IN THEIR COMMUNITIES. THUS, THE AGING NETWORK SERVES AS A VITAL AND INDISPENSABLE LINK BETWEEN THOSE PERSONS AND THE ASSISTANCE THEY NEED. BASED UPON TODAY'S DISCUSSION, I HOPE WE CAN BEGIN CONSIDERING PROPOSALS TO STRENGTHEN INFORMATION AND REFERRAL SERVICES AS PART OF NEXT YEAR'S REAUTHORIZATION OF THE OLDER AMERICANS ACT.

SIMILARLY, I HOPE THAT OUR SECOND SESSION WILL SPARK IDEAS FOR IMPROVING COMMUNICATION AND DISSEMINATION OF INFORMATION WITHIN THE AGING NETWORK. IN THIS AREA, I BELIEVE THERE ARE TWO CRITICAL ISSUES: (1) WHAT TYPES OF INFORMATION AND DATA SHOULD BE COLLECTED? AND (2) HOW SHOULD THAT INFORMATION BE SHARED WITH OTHER INTERESTED PARTIES? I LOOK FORWARD HEARING YOUR VIEWS ON THESE IMPORTANT QUESTIONS.

IN CONCLUSION, I AGAIN THANK ALL OF YOU FOR ATTENDING TODAY'S SECOND LEGISLATIVE WORKSHOP. I AM ANXIOUS TO HEAR YOUR THOUGHTS AND CONCERNS, AS WE LOOK FORWARD TO NEXT YEAR'S REAUTHORIZATION OF THIS LEGISLATION WHICH HAS PROVEN SO IMPORTANT IN THE LIVES OF OUR SENIOR CITIZENS.

Mr. **Solomon**. Thank you very much, Senator.

What we'll do now is open the floor up for questions from the audience. I appreciate the patience of our second panel. The second panel should also feel free to ask questions if they have any. If you have a question, just come up to the microphone.

Ms. **Manheimer**. I think my voice is loud enough, but in all the models——

Mr. **Solomon**. When you come to the microphone, could you identify yourself and your affiliation, please? Thank you.

STATEMENT OF SHEILA MANHEIMER, NATIONAL COUNCIL OF SENIOR CITIZENS

Ms. **Manheimer**. Sheila Manheimer, National Council of Senior Citizens, Title V of the Elder Americans Act.

In 1964 when the bill was first organized and the wording was first in there was a tremendous segment on outreach. The value of outreach right now has been denigrated to practically zilch—nothing. While we are talking about fragile people and we're talking about long-term care and we're talking about access, we're talking about access to those people who call in. Are we going to be able to truly look at the value of outreach in those communities in which we can forestall or intercede or provide services that might decrease costs if we have the services available to get in there, to evaluate, and to look at what the real needs are so that they don't get to be frail elderly. The word "outreach" to me should be "reentered into" and the value of it to cut costs.

The other issue is that I love having all these models, but what is the cost? The only model that I saw that looks at working with Blue Cross to offset the cost has been the State of Washington. Does that look like a viable method of having other models replicate that?

Thank you.

Mr. **LaMendola**. Can I make a comment about the access portion of the Denver project?

Mr. **Solomon**. Sure.

Mr. **LaMendola**. That wasn't addressed in the presentation. One of the things about the Denver project that we did not talk about in the earlier presentation was an element of public access that is designed into the project. That works in two different ways.

The project is, as Sue said, a PC-based project. But the database also runs on the major library systems in the metropolitan area. What that means is that in Colorado we have an organization called the Colorado Alliance of Research Libraries, which is one of the largest data managers in the United States. It has over 500 terminals available in the Metro area. Through those terminals an elderly person can sit down and actually look through resources that are available, do some searches of everything that is accessible on the database.

The second way that that has been designed into the library system is that in Colorado Springs, as some of you are probably aware, there is a very active SeniorNet group. Of course, you can dial in, if you have the appropriate resources, into the library system. The library system there not only has information and referral data, but it has schedules of what kinds of things are going on in the different senior centers and what kinds of activities seniors might participate in.

Now, I know that doesn't address all the access issues, but I wanted to bring to your attention that, in fact, this particular project also includes a larger element of access to the database than the one we described initially.

Mr. SOLOMON. Sheila, I'd like just to make one point. The issue of outreach will also be addressed by the second panel. Don't let me forget to come back to it when we are ready for questions and answers then.

Dick?

Mr. SUGIYAMA. I think the point of outreach is a real important one. I think one of the most painful things I have experienced is when we switched from an outreach focal to case management. We left a void there when we went to serve the extremely frail persons with case management. We skipped that step in the continuum of care that used to serve the higher functioning seniors.

While it had to be done at the time, we are now backfilling this service gap. We have got a number of programs—especially one focused with black elderly—where we added back several nutrition outreach persons. We need a person to provide outreach services.

One of the panelists mentioned the computer access system. I can't question the usage rate because I can't even access the computer a lot of times. I think you've got to have a live person providing information to callers.

We have also worked with senior service centers in King County to provide trained volunteers there, but that created some other problems, such as client confidentiality questions, client preference, and things like that.

So our third approach tried was in partnership with AARP in our region to have AARP-trained volunteers located in some of the larger senior centers to provide assistance level services.

You are correct. It is a dangerous trend to totally forget this part of the senior population.

Let me talk about Blue Cross. We have had a contract with Blue Cross of Washington and Alaska for about 3 years now. I understand that it is going to be a growing trend in California, I've received at least five calls from different counties in California about our unit rate and the care coordination role with Blue Cross. We have been providing case management services for Blue Cross enrollees. We also have a second contract with Beech Street, which represents North American Life and Casualty. So there are new directions for us.

Mr. SOLOMON. Sue.

Ms. BOYD. Yes. I just had one other comment about what is happening in Denver. I also concur that the outreach is a very important part of this effort and wanted to suggest that all of these models where we are talking about information networks are really intended to address the professional user of this information; that information then needs to be translated into the outreach efforts that are going on. I think that was what I was trying to refer to with the issue of small community agencies which are better equipped to do outreach than some of the bigger agencies that are doing I&R.

Mr. SOLOMON. Before we leave Sheila's question, I think, as important as outreach is, the issue of cost is also important. I think Doctor Al-Ibrahim talked in his statement about having to pull back on some services because of the cost or because of the funding of the services. Can you talk to just a little bit—any of the panel members who would like—about what the effect is? You are faced with these tradeoffs on a daily basis. How does it get done?

Mr. LOGAN. I think a surprise to a lot of agencies—when you computerize a lot of people will think it will solve your administrative, as well as other, problems. The surprise comes to most people when you have maintenance costs and upkeep costs.

If you have a large system like ours, the software that we were using, the license fee on a yearly basis for that many users was $10,000 a year. Clearly, we couldn't afford that once the 3-year grant ran out.

We wanted the system to operate, so our thinking was that we went to a less expensive software that had no license requirement on a yearly basis. We did that. We also are planning to bring some hospitals into the system to help. They want to be part of the system, they want the information, and they are willing to pay a minimal fee which will help keep the system operating. That was real important.

We find that people want to get involved. Hospitals want to get involved. They are willing to defray the cost.

We have learned a lot. We have learned that it is expensive. We learned that with the limited resources, if you put on a new system that takes more money to operate, in essence you are taking service away from people.

So our whole operation over the last 3 years has been how we can make this manageable. I think we are accomplishing that. But we also needed that grant to help us learn the experience, too.

Mr. SOLOMON. Doctor Al-Ibrahim.

Dr. AL-IBRAHIM. I think I described and my perspective was a medical model. I don't think that you could say anything else about the cost of screening and preventive programs. Up front they do cost money. There is no doubt about that. We, as a nation, have been very lax in providing those preventive services. However, I think that the end result is much more costly later on without them. But it does cost money to set them up.

I would reiterate what Mr. Logan said about the desire of hospitals to network into systems. They have staff that are dedicated, or, if not, they are willing to put up the staff. This is a vital concern to community hospitals. We have approached the community hospitals in our catchment area expecting there would be resistance and the usual turf and territory battles. Most of them feel very strongly that they will provide better care and they will maintain their patients as opposed to losing them. I think that there are a lot of resources available. It needs, though, some start-up funds to put the demonstration in place.

Mr. SOLOMON. Dick.

Mr. SUGIYAMA. One of our programs is actually located in a hospital setting on the east side of King County. That case management program, even within the hospital setting, still maintains a social service model—one which identifies those persons with chronic health care and social service needs. In the development of an effective service plan, we believe that it reduces the amount of re-hospitalization and subsequent nursing home placement.

Mr. **Solomon**. Go ahead, Sue.

You hit a nerve, Sheila.

Ms. **Boyd**. One other comment related to cost. The design of the model in Denver was selected to be a low-cost one. There are two dimensions to this. One is the choice of PC hardware and software. The other dimension is that the whole design is built on a base of in-kind contributions from agencies already involved in information and referral. They already have resources committed to this kind of a service. It is a case of existing service providers working together to design a cooperative model. We are shifting the use of resources rather than putting in totally new resources.

Mr. **Solomon**. Thanks.

Go ahead.

Dr. **Wertheimer**. My name is Debra Wertheimer. I am a physician. I work at Waxter Medical Services with Doctor Al-Ibrahim, as well as running the medical discharge planning at University of Maryland Hospital.

I'd like to make two comments. One is I think access and outreach are incredibly important. One of the things that I think we missed in all the presentations today is that we are waiting for people to come to the information referral services. I think that there is a huge segment of people who don't know how to access that system or who are afraid to access that system. I think that one of the things we need to think about is ways to identify those people who are at risk before they get sick or before they have social problems and try to bring them into the system and get them the resources which they are eligible for and which are available.

One of the places that happens is hospitals. It has been mentioned both by Mohamed Al-Ibrahim and Mr. Logan as a point of entry into systems. It is a point of entry which is frequently not used.

Emergency rooms, physicians, and hospitals are where many elderly—before they become frail, but certainly when they are frail—enter the system. If we don't figure out ways to link all these other resources to the hospital, I think that we are going to never capture that population which ought to be captured.

I think that one thing is we need to talk about how to access people in ways other than the more typical things that we have been talking about without creating whole new bureaucracies. The hospitals there are waiting, and I think it is something we should take advantage of. Certainly hospitals want to get into this system—at least that has been our experience.

The other thing I think we need to talk about is the fact that once people have been identified as frail, if we do begin to link them into these systems then what we can do—what I found on discharge planning is that we can prevent what was just said. We can prevent nursing home placements which are premature. We can prevent recidivism into hospitals. We can prevent people from being functionally impaired when they need not be as functionally impaired.

Finally, what we can do is utilize resources. We find over and over again that we have increased the number of uses of rehabilitation centers which allow people to become reconditioned and then go back into the community. We find people can utilize things like occupational and physical therapy in the hospitals so that their functional level is much better when they leave the hospital, and then we can link them into services.

I guess the point we would like to make is that we need to bring together both the social as well as the medical networks into a working relationship and really link these resources.

Senator PRYOR. May I ask you a question, Doctor? We have talked about the availability and accessibility and commitment of hospitals to be involved in this. Is this just large, metropolitan hospitals? I'm interested also in rural hospitals where there are 50 and 60 beds.

Dr. WERTHEIMER. I would suspect, from the community hospitals that I have dealt with in Baltimore, which are not 50- and 60-bed hospitals, that they are very interested. Many hospitals are identifying elderly as the population that they are going to be serving in the next several decades, and they need to be interested and they are beginning to put together all kinds of services to identify those people.

I think that all size hospitals are interested. These senior outreach programs are becoming what hospitals are interested in and what they are looking at. So I think it is not large hospitals. In fact, I think that large hospitals, tertiary hospitals like the University of Maryland, are going to be the most resistent to looking at the elderly and trying to come up with this kind of access.

Mr. SUGIYAMA. May I make a comment?

Mr. SOLOMON. Yes.

Mr. SUGIYAMA. On the issues of hospitals, I can support some of that in the sense that hospitals in King County and also other parts of Washington play a real important role in referring persons to our current I&A system because most of the major hospitals, at least in the Seattle area, have senior care programs in the hospitals.

I would much rather put the emphasis on a gatekeeper type of program. In Spokane, WA, they've got an innovative national model where you focus on people—other than aging network folks—who come into contact with elderly people. They do extensive training with postal delivery persons. They do extensive training with our city light customer reps. I went out with one of the gentlemen one day, and they have a computer printout which shows excessive use of energy in a particular given period. What we found when we went to the woman's house was that she was using her oven as her sole source of heating. She was simply opening the door of the oven and heating her house. It is those kinds of people that would get people into the I&A system before they get to the hospitals hopefully. But still, those people who do get to the hospitals need to have some sort of services and access.

Mr. SOLOMON. Sue.

Ms. **Boyd**. I think that we also recognize the fact that seniors access information and services from a variety of points and that hospitals clearly are one of those. But there are many others. Your point is really well taken.

In the Denver model, one of the expectations that we have is that when the integrated database is developed it will be available to other service providers that have client contact, and certainly hospitals are on that list.

Mr. **LaMendola**. One of the things the Colorado Trust discovered in 1987 when we did some initial studies of the situation with the elderly in Colorado was that the tertiary hospitals, when they serve the elderly—often the elderly would come to the metro area for procedures that were more significant than rural hospitals could handle—almost never referred back to the rural provider of service—whether it be a rural hospital, or whatever—any information about the after-care plan. So the elderly person from the rural area who went into the urban area for care left in a much worse situation that the person who lived in the metro area and then was going back home.

So one of the fantasies that we have worked on in the design of this is to actually generate this technical capacity building in such a format that it can be shared through the entire State in a very economical manner so that the rural hospitals and the tertiary care centers have some method of communicating after-care programs.

Dr. **Wertheimer**. I'd like to comment about that for one second. One of the things that I find is that probably the reason hospitals don't refer back an after-care plan is that they haven't made a very efficient after-care plan. One of the things that needs to be discussed is the fact that physicians and hospitals and all the health care providers don't think about discharge planning in an effective method and if they don't think about discharge planning they can't give you an after-care plan.

One thing that we don't talk about in this setting is that you've got to educate the providers—not just the people who are doing access and information referral, but those people to whom you are referring. If you don't do that, then you won't have an after-care plan.

One of the things we have been doing manually is, as we said, is that we develop a very extensive after-care plan which we then rely on people who are not very well attuned or educated to carry through. It often doesn't happen.

Mr. **LaMendola**. Yes. I think a part of our project was to work with Robert Wood Johnson Foundation where we have a geriatric assessment. The tertiary care center is providing training to rural teams and we have brought them on the same software so that now they can share data about after-care planning, as well as resources in both regions.

But it was only a small part of the problem that the tertiary care facility was not doing the discharge planning. In fact they were, but they weren't communicating that to anyone.

Dr. **Wertheimer**. They do the discharge, but they don't have the plan often, and they certainly don't communicate, and communication is clearly one of the key problems.

Dr. AL-IBRAHIM. I think that the kind of systems that were proposed for developing uniform or universal assessment formats at the I&R level need to be done at the hospital level, be it tertiary care or rural, to develop those kinds of mechanisms that would also educate those individuals doing the discharge planning. And then the information network is the second step which links them together.

I would reiterate just one more point. I would agree that rural hospitals have a very important place to play, as well as do small community hospitals in urban areas. Many of those have actually developed extremely good linkages with local agencies, with chronic care institutions, and they have developed outreach and homecare programs and are probably very much more interested in some ways than the tertiary care centers who do the high-tech big stuff.

Mr. SOLOMON. Thank you.

Next question?

Ms. SCHNEIDER. My name is Mary Schneider, and I'm on the staff of Senator Pressler.

My question is related to the work that Mr. Logan and Mr. Al-Ibrahim are doing.

In my own doctoral research on quality of care in nursing homes, I have uncovered an interesting, and that is what happens with people in community-based services—the outcome of those people versus the outcome of the people in nursing homes? Have you built into your systems a way of tracking the people that are in community services that have disabilities in terms of their activities of daily living? Or are you planning to do that? And are you tracking these people to see how long they stay in the community-based services and what factors are important in keeping them there versus transferring them to an institutionalized setting such as a nursing home?

Mr. LOGAN. We would love to have that data. Two things have happened in Hamilton County: one, the Living at Home Program started, so we are able, for the first time, to track people; secondly, almost in conjunction with that we started the 2176 waiver program which diverts Medicaid funds from nursing homes into homes to keep people in their own home.

What we are doing is working with the Ohio Department on Aging. We look forward, in about a year, to looking at our data and coming up with some kind of results. There is nothing as of yet. Before the data never existed; now we are starting to compile it.

Dr. AL-IBRAHIM. Doctor Wertheimer might want to comment on some of the discharge planning data. Doctor Wertheimer has been collecting prospectively some—I think there is very little data in the literature that will tell us about some of these outcomes. I don't think they exist. And the kind of models that I think people here are proposing today should make that easier to do in the long term. But I thought that Doctor Wertheimer might like to mention something about the discharge planning data that she has been collecting. Do you want to do that, Debra?

Mr. SOLOMON. It is hard to say no when he asks, isn't it?

Dr. WERTHEIMER. Right. We've been looking—again, because I do the discharge planning—at discharge planning, which I think is an enormously important subject, looking at frail elderly, particularly. There is almost no data about discharge planning and what happens and how you prevent people from coming back into the hospital. There is some data coming out now as to some of the people who really are at risk for re-hospitalizations, and those people are the ones we can all pretty much identify. The older people who are living alone who have multiple problems with activities of daily living are primarily people who have no support systems in the community.

But how to prevent them and models to try to change the way we deal with people that are hospitalized have not been done. It is very hard to do that. The outcome data that one wants to look at is very hard to access—things like the numbers of hospitalizations, things like the length of stay, nursing home readmissions, death, the use of community resources, and part A Medicare things such as community home care agencies are almost impossible to track at this point. There is now some hope that we will be able to do that as Medicare has begun to merge Part A and Part B files. We are hoping to look at that in the near future, but now there is really no way to track that information.

Mr. LAMENDOLA. If there is no more activity on your side, I'd like to comment about the access issue again because I think it is a critical one and I don't want to downgrade at all the importance of aggressive outreach by trained people by these comments. In other words, I don't want you to perceive me as saying that technology is the solution, because it isn't; but technology can assist, particularly if you have a problem that you need to solve.

I talked basically about the public library access through a technology, but, in fact, what this project will do is to train, under the Denver Library System, all the librarians in skills in critical listening, dealing with seniors who are visiting small public libraries, talking with them about the problems, and accessing by telephone actual resources that seniors need.

A second thing to be aware of is that the project also includes giving these devices, through the 911 system, to the police, to all of the city and county agencies at the point at which they deal with the public, and also to all the parks and recreation facilities. Now, they haven't obviously done all of that yet, but they are experimenting with placing these, for example, in senior highrises and training staff there to sit with elderly people and talk to them about problems.

So I think a part of what the technology in this case is doing is assisting people to access information about resources that they didn't have before.

The final thing that I'd like to say is that in terms of all older Americans, of which I am quickly getting to be a part, many people can actually get to information or referral services all on their own, so there is a whole segment of elderly people who actually are active and actually can go to the library—and I have watched them do this—and access information about services that they need all on their own. Those people today in Denver represent a draw in the service community. In other words, there is no way that they can do that right now without drawing down on the service that is available.

With the technology there, maybe we can shift a little bit so that people who are active and independent can actually do that on their own, and those people who need services can move into a different kind of a mode when they contact service providers.

Again, I'm not arguing at all about the necessity of person-to-person outreach here, but I am just talking about the technical solutions to part of that.

Mr. LOGAN. The other thing—and it goes along with this—we have had a number of different systems, and I think for each of the communities they are probably excellent. But a system won't work unless a community is behind it. A system won't work unless you get the community to help develop it and design it. You can develop the best system in the world, and if your provider agencies will have nothing to do with it then you might as well not have it.

I think ours work because they were involved in the development of the assessment, they were involved in the development of the software, and the people felt ownership in it. If it failed, they failed. It was a long process. Before that grant started, the Department of Human Services wouldn't talk to the area agency, and I have no idea why. We're really nice guys. But that's the way it was. The Catholic Social Services didn't work with other agencies. Putting these people together in a room and developing a program—if the grant wasn't awarded and we didn't develop the program, we would have won anyhow because we were together, we were talking, we were sharing. That made it work.

The byproduct was the Living at Home care coordinating system. That made everything work. And we are still talking. I think just because of that fact in the Cincinnati area services are better.

Mr. SOLOMON. I have a question for the panelists, as well as for the audience, I guess. When the Older Americans Act programs first got underway in the late 1960's and early 1970's it seems that for information referral there was much more emphasis on more traditional I&R—that is, just providing information and referrals to older people about everything under the sun potentially—I suppose everything from transportation, bus schedules, activities in the community, where one goes to get a lawyer that is affordable, to health care concerns. From the discussion this morning and from the models, it sounds like the emphasis in I&R or I&A has shifted in many cases toward health care and perhaps more specifically toward long-term care, and more specifically towards a feed-in to case management in many cases.

Now, in Denver, from the discussion, there wasn't much discussion about what exactly you deal with in I&R, but I assume this is more generic, traditional I&R, but that may not be correct.

I guess as Congress looks toward reauthorization in 1991, as well as just people in the aging network as they are looking toward information needs of older people, should there be a conscious effort, or is there a consensus that perhaps I&R ought to be moving towards either focusing almost exclusively on health care or long-term care? I ask that simply as a question, because that is a large part of the discussion here. Or should there be an emphasis on developing specialized I&R systems like in Cincinnati that are subsets or ancillary to a broader community I&R?

I guess my editorial comment is that while we talk so much about long-term care and health care, which is mostly what I work on, there obviously are lots of other areas of needs that older people have, from housing, from employment—many other areas that I think many older people have very difficult times accessing or getting information about.

So that is kind of an open-ended question to everyone.

Ms. ABRAMS. I have a big concern because there has been much discussion of particular programs known to members of the first panel and there are many other things we do in Maryland. The second panel hasn't had a chance to say anything and I'm chafing at the bit. We'd like to comment before you get into your specific question, because we have some programs going on that might be models to look at and some of the issues now being discussed have been addressed. There are some things I was going to talk about later, but believe we have to talk about now. I just wanted to say let's have the second panel have a shot at the questions being raised now.

Ms. BOYD. Is it all right to respond? Regarding the issue of what kind of information elderly and seniors need, I think there is a whole spectrum of needs. The thing that is happening is that the vast amount of information, and in some cases the specialization of that information, makes this very complicated.

You are right. The Denver model does call for a more traditional look at the information needs of seniors. We find that some of the most difficult needs to meet are the ones that are very basic and not necessarily always in the health care arena. But we also see a need to network all of those different pieces of information so that health care information is not completely separate and apart from some of the more general pieces.

Although health care is a major issue—probably because of the costs associated with it, as well as the specialization—it is very important, but I would want to say I hope we don't lose sight of some of the other kinds of information the seniors need.

Mr. SOLOMON. Thank you, Sue.

I do want to say that one of the fondest dreams I could have would be for the audience and the second panel to be so anxious to have their turn that right now I'm sort of in a little quandary on whether to have people come from the audience up or get to the second panel. What might be better—let me just suggest this, and since I'm the moderator maybe this is what we'll do—is let's hop to the second panel. I'm going to skip the break. If you want to stand up and stretch your legs, feel free to do so. I'm going to do the same thing. But I think the issues are so related that it really does cause problems to keep the second panel waiting.

We'll take 5 minutes, and then come on back. No more than 5 minutes.

[Recess.]

Mr. SOLOMON. We will reconvene the second session, please.

The second topic we will be talking about today is the topic of information flow. As you can see, it is directly and totally related to the first subject.

The panel members on the second panel have had experience and interest in programs of their own that get to some of the issues we were discussing before we took our break.

What we'll be talking about in the second session is how effective the information flow is within the Aging Network. We'll be defining information flow as consisting not just to the data that are collected and provided to the Aging Network, but also the process by which this information gets disseminated—flows up and down within the Aging Network.

As Sheila talked about outreach, it is the first and most important part of any kind of information flow. If you don't know what is there, you have your problems.

We are very fortunate to have our second panel with us today. Sitting on the second panel are: Mr. William Bechill, Associate Professor, School of Social Work and Community Planning, University of Maryland at Baltimore; State Senator Rosalie S. Abrams, Director, Maryland State Office on Aging; Ms. Cheryll Schramm, Director of the Atlanta Regional Commission; and Mr. Jim Loftis, Executive Director, Services and Opportunities for Seniors of North Little Rock, Inc.

We'll begin this session with Mr. Bechill providing some background on the topic of information flow. He'll talk about issues such as presenting a conceptual framework for information flow, what he considers to be inherent strengths and weaknesses of this system, and recommendations to improve information flow within the aging network.

Then each of the other panelist will in turn address one or more of the following issues: The effectiveness of lines of communication, what kind of data is currently required, how data currently collected is used, types of data that should be collected, additional information that could be provided to the aging network that would improve the agency's operations. Another issue they may discuss is the issue of technical assistance—what is provided and what should be provided.

And, of course, we have asked them all if they can to address any ideas or issues that they have in relation to the reauthorization of the legislation.

With that, our first speaker on the second panel will be Mr. William Bechill, Associate Professor, School of Social Work and Community Planning, University of Maryland at Baltimore. His efforts in the area of aging issues are quite extensive and well known. He has written numerous articles and his contributed to many, many committees and other professional organizations. For example, Mr. Bechill is a former U.S. Commissioner on Aging and Executive Secretary of the Citizens Advisory Committee on Aging. He served as Chairman for the Committee on Aging of the Maryland Conference of Social Concern, and has served on the University of Maryland's Task Force on Long Term Care and the Committee on Geriatrics and Gerontology. He received the Arthur S. Fleming Lecture Award from the National Association of State Units on Aging.

Bill, if you could start our second panel off, please? Thank you.

STATEMENT OF WILLIAM BECHILL, ASSOCIATE PROFESSOR, SCHOOL OF SOCIAL WORK AND COMMUNITY PLANNING, UNIVERSITY OF MARYLAND, BALTIMORE, MD

Mr. BECHILL. Thank you very much, Jim.

First of all, I would like to express my appreciation for being a part of this workshop. I am very pleased to be on a panel with my colleague and good friend, Mrs. Rosalie Abrams, who is the Director of the Maryland Office of Aging. She has provided the State of Maryland with excellent leadership and is a strong advocate in behalf of older people in our State. I needed to say that very much.

I just want to make some observations about the Aging Network. It is, of course, a program that I am very happy to have been identified with as it has evolved over the last 25 years. I feel as positive about this program now as I did 25 years ago when it started.

I'm going to summarize what I am saying from my remarks.

The first is that as it has evolved, it is a very diverse and somewhat complex network. You have mentioned the various components in it—the Administration on Aging, the various State units on aging, the area offices on aging, I mention in my testimony the tribal organizations who are also receiving money under the Act, and, of course, at the local service provider level literally thousands of direct service provider organizations that are providing services under approved area or State plans.

It is also a network that over the years has been subject to an increasing number of program priorities as a result of the so-called targeting strategy that is developed in the Older Americans Act legislation, and I think that has been a trend that has been underway now for some time.

But I want to mention another part of the responsibility here that is not necessarily related to the Act, itself, but is very much related to the responsibilities of both State and area offices on aging.

Now, I think if there were a careful examination done today it would show that both area agencies on aging and the various State units on aging have responsibilities that are beyond or in addition to those imposed by the Older American Act legislation. I mention in my testimony that we have had a number of such initiatives in the State of Maryland in the last several years as the result of leadership both in our executive and legislative branches of government in behalf of older people.

At the area level, I see this also present in terms of some of the initiatives that have been taken by county governments in the State of Maryland, one being Baltimore County which literally developed a senior center network almost entirely on its own initiative, and one for special transportation services for older people that developed in Anne Arundel County over the past two decades.

A second observation is that there is a considerable amount of reporting requirements and statistics that need to be collected with respect to the various mandates that are now set out in particularly the Title III provision of the Act. These are mandates that require—very precise mandates that require that identification of the numbers of people being served, the service categories, their demographic characteristics, and the like.

As a result of the reauthorization legislation of 1987, the Administration on Aging and the State units on aging are now collecting data relative to the needs of other groups. I'll mention two—the disabled, older population; and those with Alzheimer's disease.

Then, there are the programmatic emphases that are built into the Title III provisions that have to do with the performance of senior centers and other parts of the so-called supportive services part of Title III—the congregate meals and home-delivered meal program and a new in-home services section of that particular title of the Act.

Some attention should be given in considering the reauthorization of the Act to what we have really been talking about here today to some degree—what are the information needs? What are the information demands of the various parts of the aging network? And what kind of reporting is really vital to performing the various mandates that are set out in State and national legislation? What kinds of national databases should exist to assist the Administration on Aging, State units on aging, area agencies on aging, and service providers?

There is an omission in my testimony, but I'd like to insert it. For example, I have felt for some time that we have needed to have a national databank with relation to senior centers and senior center programs. That would be very helpful in terms of programming.

A few years ago I participated at AOA's request in a study of the training needs of the field of aging. I think there is a need for some kind of database that would more clearly identify the personnel needs both on a professional and paraprofessional basis that we now are going to need not only now, but in the period ahead.

To my knowledge, there has not been an empirical study of the information flow either in the vertical dimensions that are up there or there horizontal dimensions of the Older Americans Act. One is needed.

The reason I say that is my impression is people in the network are now devoting too much time to the filling out of reports and meeting other informational demands that are now required as a result of the way the Act is structured. I appreciate the fact that a certain level of reporting is necessary for accountability purposes, but my frank impression is that too much time is now being spent in the network by people on the generation of information that may not be used and, more critically perhaps, may not be actually necessary.

There are one or two other areas that I would like to comment on. One is the area of technical assistance. I believe that the Congress should take steps during the 1991 reauthorization to enhance the capability of both the Administration on Aging and the State units on aging to provide technical assistance—particularly to the area agencies and to the direct service provider agencies.

I think it is important particularly to get the AOA staff out of the regional offices and into the State and local communities. There have been constraints and restraints on them, but I think it is very important that there is this more personal interaction with the State and area agency personnel.

I believe that the entire field of aging should be able to look to the Administration on Aging and to the State units on aging, as they do, for such useful help and guidance and expertise at all times.

I don't want to suggest that a level of that kind is not available now, but it could be enhanced and it could be improved, in my judgment.

There was one comment made in relation to outreach and the importance of outreach. I would just like to mention that as part of my responsibility at the University currently, I am directing an exploratory study looking at the reasons why older black men in Baltimore City are such low users of both existing health and social services. I think this is probably attributable to a number of factors. I won't go into those today.

In the process of just developing some background information for this study, it has forced me again to look at some of the data and information we have with respect to the low income older population in both Maryland and the City of Baltimore, with respect particularly to the availability of such programs as the supplemental security income program, Medicaid, and the like.

Without going into those statistics, it is quite clear that we are not reaching a very substantial number of low income older people through our existing efforts, which have really been considerable. We still are not reaching that propulation to the degree that perhaps we should.

I don't think the situation in Baltimore City or the State of Maryland is unique.

Thank you.

Mr. **SOLOMON**. Thank you for that introduction, Bill.

Our second panelist will be State Senator Rosalie S. Abrams, Director of the Maryland State Office on Aging. I'm very, very honored to introduce her.

Senator Abrams, a native of Baltimore who received her bachelor and master's degrees from Johns Hopkins University, is an experienced businesswoman, health professional, legislator, and now Director of the State Office on Aging. Her accomplishments are extensive and impressive. Let me just comment on some of her activities.

Senator Abrams was appointed by Governor Hughes to serve as the Director on the Office on Aging in 1983 and was reappointed by Governor Schaeffer in 1987. She has directed her efforts to educating the senior population of Maryland on the issues concerning them and in coordinating the many programs and services available to them. She has developed the innovative Senior Reach and Gatekeeping Programs.

Having had a chance to read her presentation before you did, I can understand why she was so anxious to tell us about some of these programs when the other questions were coming up.

Senator.

STATEMENT OF ROSALIE S. ABRAMS, DIRECTOR, MARYLAND STATE OFFICE ON AGING, BALTIMORE, MD

Ms. **ABRAMS**. Thank you very much.

I am going to depart from my testimony as written because I do want to underscore what Bill Bechill has said.

We are very much in sync in that we believe that there really is a national problem, and it isn't only in aging, but it is in every human service field. People use definitions and use words that don't mean the same thing to everybody. Somebody goes out and says they are paying a home visit. Is it a one-hour visit? Is it a 10-minute visit? Is it a day-long visit? If they do six things, is it six separate visits? If it is partly funded by three different units of government, is it three different visits? That's the way things are getting counted. Everybody is looking at things differently. That's a major problem that cuts across all human delivery systems. What are we talking about? Everybody uses a different system. And the more people there are that deal with one bit of information, the greater variability there is in it.

For example, we were required to identify minorities served. Well, we can't ask people over the phone "are you black? Chinese? Puerto Rican?"—and if their name doesn't show it what can we do? And if they are married to someone of another ethnic group, what help do you get from a name? That doesn't really give us a lot of indication.

So we have had to guess mostly. I must tell you we guess a lot at what we report, so I don't want you to think that the information that is coming through is accurate, because it isn't. It is as good as we can make it,but some of the things we are requiring—and even at the State level—are too much. We have a committee working with the area agencies on aging now to look at what we require.

We do have a very good relationship with our area agencies on aging. I see some of the directors sitting here, so I'm not even going to look at them to see if they nod or shake their heads. [Laughter.]

Ms. Abrams. I think it is a good system. We work with area agencies when we develop formulas, and we try to reach a consensus. We don't always reach a consensus. I serve on a board of directors where there is consensus. We generally try to overcome some of the principal problems that people have, and we work with them so that when finally the decision comes out it is not a shock to anybody because they have been part of the decisionmaking.

There is a local MAAAA—Maryland Association of Area Agencies on Aging—who meet monthly, with whom we have wonderful communication. They give us an opportunity to talk every other month, and we can talk every month if we want to. We do discuss with them practically everything we do—even before we do it.

We think that there needs to be a collaborative effort by the Census Bureau, the National Institute on Aging, the National Center for Health Statistics, and the Administration on Aging to develop social indicators of unmet need and to develop uniform standard-setting definitions of key supportive services; otherwise we are talking about various kinds of services and we're not all talking about the same things.

Incidentally, Maryland was the first State to develop a commission to establish hospital rates, and I was part of that. That commission works because from 1968 to 1971 it was voluntary for hospitals to adopt uniform cost accounting procedures. From 1971 to 1975 it was mandatory.

Uniform data collection is very important if you are comparing information; otherwise, you are just playing with numbers and they are not meaningful.

When you talk about unmet need you have got to begin to develop uniform ways of assessing need and you have to begin going out into the community.

Bill Bechill came to see me a few weeks ago about outreach to identify people on SSI. This raises another problem. On of the things I said to him was, "Aren't the people we identify then going to be eligible for Medicaid?" I said, "I'd better be talking to the Governor before I tell you the State of Maryland is going to actively participate. Why would we want to identify them if we can't give them the services that are needed?" That's another major problem we have.

In the State of Maryland we put very, very, very top priority on outreach in a different way. First of all, we don't think the medical model is so great. I personally think it has a lot of problems. Medicaid and Medicare—Medicaid primarily—a medical model? You don't need a medical model to know that somebody needs housekeeping services. You don't need a medical model to know that a lonely old lady in a high-rise facility who has been aging in place there for 10 years and may stay there another 20 years needs somebody to talk to who understands what she is talking about. She needs transportation to her doctor, she needs housing, she needs housekeeping, she needs somebody to help her with her bath. None of these things need a medical model. You don't need to be a doctor or a nurse—and I happen to be a nurse too, incidentally—you don't need to be a professional to identify a need.

I think if we could get away from the medical model we'd be doing a great service for the aging community.

Long-term care includes everything—everything. The aging network, it seems to me, is in a very critical position. We cut across every possible kind of service, and we are providing a new dimension. In some of our counties the aging network is setting up transportation systems. That is happening in Harford County. Two counties--Harford County and Calvert County—are setting up transportation systems for outreach into the rural areas that will eventually be used by everybody. They are now being developed for the aging.

We are identifying a lot of needs out there. Transportation is one of those supportive services that everybody needs. It has got to be a critical part of long-term care. Long-term care is not just health care. In fact, health care may be the end result of failing to provide some of the other kinds of supportive services that people need to remain healthy and in the community, including nutrition, including opportunity for companionship, including other kinds of activity.

Now that I've gotten that out of my system let me talk about what you really asked me to talk about—SeniorReach, outreach. This is our logo. We are going to try to get it patented, incidentally, because we think it is so great.

This program uses the existing communication systems of practically all the major corporations of Maryland, including the utility companies and a lot of other private corporations, such as the

Giant food stores, for example. They pay for it, incidentally. All we do is sign a contract with them and they agree to do this. We give them information; and they use that information in communication with their employees. We know a lot of employees are taking care of older people. They are, indeed, the sandwich generation, as described by Sylvia Porter.

We give them information about services that are available in the community for the employees to use, as well as for their families and other older people who really need the services.

They are now providing information. We are going to them now and talking about their providing services, incidentally.

Our next group that we are going after is the medical society—the doctors whom I have been trying to set up a relationship with for a long time. I had a great relationship when I was a member of the legislature. But they don't want anybody telling them how to prescribe for old people, how to give information—which I'd like to tell them, but they don't want to hear that.

We would like to give them information about services available. Doctors are in a key position. They are the first contact usually with an older person. They ought to know what is out there in the community and they don't.

We work already with several hospitals, and we think we ought to work with every hospital. I put a proposal in several years ago to the Governor that said every patient that gets admitted has to have a pre-admission discharge plan. Hospitals said, "No, you don't want to mandate that. We'll do it." Well, you see how they are doing it. One of the things that has happened today is I think I'm going to propose that bill again. You need to keep people's feet to the fire.

All of your people need a range of support services, and they need information. You have to use anything you can. We get out guidebooks; we worked with the Insurance Commissioner to put out the first guidebook on Medicare and MediGap policies available. We have revised it several times and have given out over 100,000 copies of our first printing alone.

We work with the Attorney General's office on all kinds of issues—living wills, Medicare assignment, cutting health care costs, consumer protection—in every possible way that we can.

We get funding from private corporations; we get money from national organizations. We work with the United Seniors Health Cooperative, who helped us with the commuter software to help give people information immediately on the kinds of benefits available to them.

We work very, very well with the area agencies on aging. I mentioned that earlier. We work well with local government.

The big problem we have, of course, once you identify a need is whether the money is available for services. You can't separate them, but we do believe there is a great need to look at the kinds of information we are requiring to decide if they are necessary, if they are really going to be used. Are the forms too complex? People are the ones who fill out the forms and provide us the information. We have to recognize that there are problems.

Thank you.

[Prepared statement of Rosalie Abrams follows:]

THE OLDER AMERICANS ACT:
INFORMATION SYSTEMS FOR CONSUMERS AND THE AGING NETWORK

Statement by Rosalie S. Abrams
Director, Maryland Office on Aging
to
Senate Special Committee on Aging

April 19, 1990

I am pleased to be with you at your workshop today to discuss information systems for consumers and the aging network. I will present information on some of the key information systems we have developed for consumers and for Area Agencies and providers within the aging network. I hope what we have learned as we have undertaken innovative information systems development will be useful to you as you consider changes as the Older Americans Act is reauthorized.

Maryland is home to 735,316 persons aged 60 and over, representing almost 16% of our state's total population. By the year 2005, 18% of our population will be aged 60 or over. Like other states, Maryland is experiencing an especially rapid growth in its 85 and over population. Currently, 50,509 people who live in Maryland are age 85 or older. By the year 2005 that number will increase to 95,817, almost double today's number. As we look to the future, we know that it will increasingly be the very old who will be looking to us for services.

Your topic today is very important as we look to the future of the Older Americans Act and try to enhance our ability to respond to the changing needs of elderly citizens. The old cliche that information is power is increasingly true. The Older Americans Act has as its goal helping older citizens live independently and with dignity in their homes and communities. To help consumers themselves make wise decisions that enhance their independence and to help the providers in the network who are serving them, we need to continually update our information systems. My talk today will focus on our efforts to improve how information is conveyed to both consumers and the aging network.

CONSUMER INFORMATION

SENIOR INFORMATION AND ASSISTANCE

We are very proud of our Senior Information and Assistance activity in Maryland. Senior Information and Assistance is a statewide program to provide local "one-stop centers" for information and assistance about federal, state and local services and benefits for older persons. A unique feature is a mandate in state law for follow-up by Senior I and A staff to determine whether the available services were actually received. The Senior I and A sites are available for walk-in service at senior centers or nutrition sites administered by the Area Agencies on Aging. Telephone service is also offered. There are 24 main offices (one in each county) and 184 neighborhood satellite sites throughout the state. A typical county has 1 main office and 8 neighborhood satellite sites. In the current fiscal year, we expect to serve 172,000 people, approximately a quarter of whom are minority individuals.

During the past two years, we have expanded the scope of Senior Information and Assistance in several ways. First, we implemented the Gatekeeper Program, in which meter reader and other utility company personnel who identify older persons in need refer them to local Senior Information and Assistance offices for help. Since this program was initiated almost two years ago, over 1000 persons have been referred for help by utility personnel.

We are also working to strengthen Senior Information and Assistance by using the Benefits Outreach and Screening Software developed by the United Seniors Health Cooperative at each site. The BOSS software provides older persons with a computerized print-out showing the services and benefits for which they may be eligible. BOSS provides information on 31 different federal and state programs, and, in the six largest jurisdictions, provides information on local programs. The combination of accessible locations, cooperation with the utilities in locating needy citizens, and use of computer technology makes Senior Information and Assistance in Maryland a very successful activity.

SENIORREACH

Another very exciting consumer information activity is SeniorReach. SeniorReach is a statewide information campaign to enlist corporate, private, and public partners in efforts to increase public awareness of services and benefits available to older persons and to enlist the support of the corporations in projects to serve the elderly. Channels of communication already in place, such as corporate newsletters, billing statements, bookmarks, telephone sticker, and other approaches are used to disseminate information prepared by the Office to persons with whom the SeniorReach partners communicate.

Right now there are 22 SeniorReach partners including the Maryland Pharmacists Association, the Giant Food Company, several banks, a television station, several utility companies, and a hospital. The Office on Aging sends to all SeniorReach partners information and/or articles on services, programs, and benefits available to older persons on a bi-monthly basis. SeniorReach partners then publish this information in newsletters or other communications media. Examples of the subjects we have sent to partners are: Senior Employment, Adult Day Care, Census '90, Housing options, and wellness promotion.

We know that the SeniorReach partners can reach consumers who do not know about or use the services of the aging network. SeniorReach partners are especially suited for reaching working caregivers who, as employees of participating companies, regularly receive information from their employers. The public agencies will never be able to reach by themselves all the people who need information on services. SeniorReach is a way to build coalitions with the private sector, initially aimed at providing information and, ultimately, at increasing the availability of services.

CONSUMER GUIDEBOOKS

Let me briefly mention another of our most successful approaches to providing information to people: producing detailed consumer guides on health insurance and on private long term care insurance. Many people rely extensively on magazines like Consumer Reports to provide them with information on purchasing decisions. Unfortunately, a national magazine can not provide enough detail to help people make decisions about health insurance which varies in coverage and availability based on state law and regulation. The Office developed in 1985 a detailed guidebook to Medigap health insurance which listed rates and benefits for all insurers licensed to offer policies in Maryland and offered tips to consumers who were considering purchasing policies. The guide was updated in 1987 and again in 1989 (although never published due to repeal of the Catastrophic Coverage Act). We distributed 100,000 copies of the book to the aging network, to libraries, and to individual citizens.

In 1989, we printed a similar guidebook on long term care insurance. This book compares the coverage and prices of all the companies licensed to sell long term care insurance in Maryland and provides a question and answer section which provides answers to commonly asked questions. 20,000 copies of this book have been printed so far.

We would urge other states to develop specific consumer guides for residents of their states. With decisions about aging services increasingly being made at the state rather than the federal level, states--and especially state units on aging--must be the focal point for distribution of consumer information.

AGING NETWORK INFORMATION

COMMUNICATION WITH THE ADMINISTRATION ON AGING

Primary communication with the Administration on Aging takes place with regional office staff. Additional written communication is received from the Commissioner's Office. While communication lines are excellent with all AoA staff, limited travel resources of regional staff hamper optiomal communications. We feel that more frequent field visits by regional staff would be helpful in the provision of more effective technical assistance.

COMMUNICATION WITH AREA AGENCIES ON AGING

Now let me discuss information flow within Maryland's aging network. At the state level, communication between the state unit and the Area Agencies on Aging is essential if the goals set forth by the Older Americans Act and by state government are to be carried out. In Maryland, we are fortunate to have an excellent working relationship with each Area Agency on Aging. This relationship is nurtured in several ways.

First, Area Agencies in Maryland have joined together to form the Maryland Association of Area Agencies on Aging (M4A). This organization meets monthly to discuss policies, share "best practices", share information, and solve problems. The Office on Aging uses the M4A as a forum for discussing and reviewing policy changes and developing equitable solutions to statewide problems. When the Office was developing the minimum percentage expenditure requirements mandated by the 1987 Amendments to the Older Americans Act, it presented a draft of its proposal to M4A for review and comment. The Office will be working with a committee of M4A to review its intrastate funding formula and determine whether changes are needed in it. We also review with M4A our legislative and budgetary proposals prior to this submittal. While it is probably not necessary to require within the Older Americans Act that each state have a formal organization of Area Agencies, it is essential that communication between the state and Area Agencies occur regularly. The development of a formal organization is one of the best ways to achieve that.

DATA MANAGEMENT AT STATE LEVEL

We have formed a committee of Area Agencies in Maryland to examine data management in the aging network. Because of rapid growth in the number and types of services the aging network administers, many new reporting requirements have been imposed on Area Agencies in recent years. As we examined our own requirements, we discovered that we require Area Agencies on Aging to complete 26 different forms. We are undertaking a comprehensive examination of our forms with the objective of eliminating any data elements that are not needed, are available from other sources, or put an undue burden on Area Agencies or service providers. After a careful examination of the data elements on each of our forms, we expect to reduce the number of data elements we require of the AAAs.

DATA MANAGEMENT AT FEDERAL LEVEL

We urge the Administration on Aging to undertake an examination of the data requirements it imposes on states. As part of the reporting form states submit to AoA, we report on 25 different categories of Title III services. Each state aggregates data from its Area Agencies to develop the report. Area Agencies of diverse size and staffing capability aggregate data from service providers to develop the forms they submit to the state. At the state and Area Agency level, staff must determine what a particular service should be called and in which of the 25 categories it fits. The more filters data goes through, the more likely there is to be error. Given the diffuseness of the aging network, the data AoA receives is quite likely to be subject to error.

We know that Congress is interested in AoA developing more uniform data that allows comparison among states. To accomplish this, AoA may wish to regularly collect information from a sample of states and AAAs to assure uniformity of data.

NEEDS DATA

We know that, in addition to program performance data, Congress is interested in assuring that AoA collects nationwide data on needs of the elderly. The reports submitted by states last year used a variety of methodologies and approaches that did not facilitate comparison across states. We urge Congress to ask AoA to work with the states and Area Agencies to develop a common strategy for needs data to be used in submitting reports to you. Developing a common strategy across states will be a difficult task, but it is preferable to the mish-mash of responses that were the results of AoA's recent foray into needs assessment.

TECHNICAL ASSISTANCE

We urge Congress to require the Administration on Aging to strengthen its role in technical assistance. The provision of technical assistance is a key issue in information flow. However, it has been our experience that it is difficult to locate subject matter experts at AoA who can offer guidance on key Older Americans Act programs such as nutrition, transportation, and senior centers. AoA contracts with outside organizations for technical assistance on specialized topics like ombudsman services and legal assistance, but the services we receive from them are, by necessity, episodic and sometimes limited to one-time-only seminars, conference calls, or training manuals. We need to be able to get ongoing advice from AoA about carrying out the mission of the Older Americans Act. We do not want AoA to try to make every state's service like every other state's. However, we do want to be able to turn to AoA for advice and assistance, in other words, for information.

Thank you for the opportunity to present my views on information systems for consumers and the aging network. I look forward to working with you in the future on these and other issues related to the reauthorization of the Older Americans Act.

THE OLDER AMERICANS ACT: INFORMATION SYSTEMS FOR CONSUMERS AND THE AGING NETWORK

Addendum to the Statement by Rosalie S. Abrams
Director, Maryland Office on Aging
to
Senate Special Committee on Aging

(1) **How effective are the lines of communication between the national office of the Administration on Aging, its regional office, and your state unit on aging?**

Primary communication with the Administration on Aging takes place with regional office staff. Additional written communication is received from the Commissioners's Office. While communication lines are excellent with all AoA staff, limited travel resources of regional staff hamper optiomal communications. We feel that more frequent field visits by regional staff would be helpful in the provision of more effective technical assistance.

(2) **What types of data are you required to collect?**

DATA MANAGEMENT AT STATE LEVEL
We have formed a committee of Area Agencies in Maryland to examine data management in the aging network. Because of rapid growth in the number and types of services the aging network administers, many new reporting requirements have been imposed on Area Agencies in recent years. As we examined our own requirements, we discovered that we require Area Agencies on Aging to complete 26 different forms. We are undertaking a comprehensive examination of our forms with the objective of eliminating any data elements that are not needed, are available from other sources, or put an undue burden on Area Agencies or service providers. After a careful examination of the data elements on each of our forms, we expect to reduce the number of data elements we require of the AAAs.

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(3) **How do you use the data and information that you are currently collecting?**

Office on Aging data includes justification for budget requests; monitoring local program performance; providing information to the legislature and public on specific program activities and general information about the aging population of Maryland; and generally for program planning.

(4) **What types of data ought to be collected?**

See: Response to Question 2

(5) **What additional information could AOA provide to assist you in operating your agency?**

See: response to Question 10 regarding technical assistance.

(6) **How do you collect and disseminate information from and among AAAs and service providers within your state?**

First, Area Agencies in Maryland have joined together to form the Maryland Association of Area Agencies on Aging (M4A). This organization meets monthly to discuss policies, share "best practices", share information, and solve problems. The Office on Aging uses the M4A as a forum for discussing and reviewing policy changes and developing equitable solutions to statewide problems. When the Office was developing the minimum percentage expenditure requirements mandated by the 1987 Amendments to the Older Americans Act, it presented a draft of its proposal to M4A for review and comment. The Office will be working with a committee of M4A to review its intrastate funding formula and determine whether changes are needed in it. We also review with M4A our legislative and budgetary proposals prior to this submittal. While it is probably not necessary to require within the Older Americans Act that each state have a formal organization of Area Agencies, it is essential that communication between the state and Area Agencies occur regularly. The development of a formal organization is one of the best ways to achieve that.

(7) **How do you identify and share information about innovative programs or methods of delivering services within your state?**

See number 6 above and 8 below
Additionally, the Office on Aging disseminates information to other States through distribution of legislative summaries through the National Association of State Units on Aging and aging newsletters.

(8) **How do you notify AAAs and service providers of policy directives?**

In Maryland, the primary service providers are the AAAs. We have instituted a written program directive/information memorandum system similar to that used by AoA to inform AAAs of policy directives and general information of interest. The AAAs disseminate information to the service providers that they contract with.

Program staff provide written communication to non-AAA service providers, such as housing managers, on a regular basis.

(9) **What technical assistance (i.e., training and guidance regarding development and operation of a service delivery system) do you offer to persons who provide, or are interested in providing, OAA-funded services?**

AAAs provide training and guidance to their service providers. Many of our program staff have routine monthly/quarterly in-service training meetings with AAA program staff. Housing staff have annual training sessions.

(10) **What technical assistance ought to be provided?**

We urge Congress to require the Administration on Aging to strengthen its role in technical assistance. The provision of technical assistance is a key issue in information flow. However, it has been our experience that it is difficult to locate subject matter experts at AoA who can offer guidance on key Older Americans Act programs such as nutrition, transportation, and senior centers. AoA contracts with outside organizations for technical assistance on specialized topics like ombudsman services and legal assistance, but the services we receive from them are, by necessity, episodic and sometimes limited to one-time-only seminars, conference calls, or training manuals. We need to be able to get ongoing advice from AoA about carrying out the mission of the Older Americans Act. We do not want AoA to try to make every state's service like every other state's. However, we do want to be able to turn to AoA for advice and assistance, in other words, for information.

(11) **What legislative and administrative steps could be taken in order to improve communication flow through the Aging network?**

Increased travel allowances for AoA regional staff would allow program specialists to more frequently provide State Office staff with direct "hands on" technical assistance. While regional office staff are very helpful in providing written and telephone advice, additional time and resources should be allocated for site visits.

Mr. Solomon. Thank you, Senator.

The third panel member is Cheryll Schramm. Cheryll is Chief of the Aging Services Division of the Atlanta Regional Commission and Director of the Area Agency on Aging.

Upon completion of her master's degree from the George Warren Brown School of Social Work of Washington University of St. Louis, Ms. Schramm has been involved in health care in the aging network.

In addition to her role in the Regional Commission, Ms. Schramm also teaches courses on gerontology at Georgia State University. Cheryll is also on the board of directors of the Georgia Gerontology Society and the Southeastern Area Agency on Aging Associations, among others. She is also a committee Chairman on Aging Atlanta 2010.

Cheryll.

STATEMENT OF CHERYLL SCHRAMM, DIRECTOR, ATLANTA REGIONAL COMMISSION, ATLANTA, GA

Ms. Schramm. Thank you.

I was asked to speak about the information flow vertically, meaning with the Older Americans Act network, and then horizontally from all of the other perspectives where we receive information, and then what we do as AAA to distribute and disseminate this information, and then, finally, my recommendations relative to the reauthorization.

I would like to refer to my graphic handout.* I had planned to show slides, and they told me it was not the room to show slides. I still lugged up my slide projector thinking surely they're mistaken—but they were right. But I wanted to walk through with you the system graphically. I think it might be a little easier to understand. It is identified by this cover sheet. My remarks will reference what is in the graphic package.

To begin with, in the vertical system, in receiving information, as all of you know the Administration on Aging is at the top of the vertical list, and then information passes through the regional AOA through the State to the AAA, and then we work with OAA providers and the community, at large.

I totally agreed with Mr. Bechill when he was saying that our role and responsibility has gone far beyond working with just programs or services that are funded by the Older Americans Act.

The second graphic is about the information that we collect. We receive a lot of information from many sources, but then we are specifically required to collect certain information and move it back up the system. As Senator Abrams said, many times we must spend what seems to me an inordinate amount of time to collect this information. This was just one example.

I agree that such information needs to be collected, but I do think that it is taking away from many other things that we could be doing and shoud be doing.

Now, moving on, I think where it gets really complicated is the network we work with outside of the OAA system. It is so extensive that I had to go into two pages. It is the next two pages. It shows Atlanta Regional Commission, as the AAA, working with the county and State offices, with regional and national information, with other Federal organizations. Again, this has increased tremendously in the last couple of years with HCFA and with Social Security and with the Department of Labor and Department of Transportation. We are the privotal point for many of these departments, in addition to the Administration of Aging.

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* See p. 285.

We receive a lot of information through publications. We work with the private sector. We are more and more developing relationships with the private sector in not only receiving information from them, but sharing information back to them.

The community at large—we receive a lot of information from universities, form churches, etc., form providers—and not just Older American Act providers. We have over 1,500 providers listed in our information system. This goes far beyond those providers providing just OAA-funded services.

AARP continues to be an excellent source of information for us. And then other AAAs. There are approximately 670 AAAs across the United States, and we have a very active network and we use each other all the time.

The next graphic—unfortunately, as we copied it didn't show all of the lines across the United States, but many people who access our information system need information from other areas of the country. We pick up the phone and work with other AAAs all the time, and they do the same.

Now, what do we do with the information we receive? We have developed a comprehensive information system—again, this has been over the last couple of year. Our responsibility has shifted to working directly with OAA services to working with many, many people across the region and across the State and United States.

We have developed what we call an aging information system. It is interesting to note that several years ago when we first developed the system we just had a service called "Aging Connection," about which I left a brochure at the front table. That's how we started the system. That was just information referral to the general public.

Well, we have grown considerably over the last 9 years in how we have expanded that. At the center of our aging information system we have an aging resource center. That is described somewhat on the next page.

We have a computerized provider base of 1,500 providers, and we have gone beyond our eight-county region and we have information listed for 42 counties surrounding the Atlanta region. We have extensive demographic data. We have the advantage of being housed within a regional development center or Council of Government, so we have an entire Data Department.

We have an Aging Information Library. Every bit of information we get goes in the computer and also into a manual file so we can access it readily. Believe me, there are changes all the time with Medicare, with Medicaid, and many other services.

We have education and training information.

The next three have been really developed because of the public demand, one being program development packages. Everybody wants to turn their home into a personal care home or an adult day care center or whatever and they think they can make some money and also help everyone, so more and more we have been asked how you set up an adult day care center, how you do this, how you do that. So we are putting together information packages with all of the Health Department requirements, zoning requirements, etc., and then we can send these packages.

We are also seen as probably the central point to provide funding information and resource development. Again, the Older Americans Act used to be an 80 percent funding source for many of our agencies, and it has slipped to 40 or 50 percent because the demands continue to grow and the moneys through the Old Americans Act system hasn't. So people are looking at all other options.

And then, finally, within our resource center we have employment opportunities. We have students, we have people getting into second careers that really want to get into aging. They send their resume to different places, but it sort of gets lost, so we have developed this service that we maintain resumes, and then people will call us and ask us if we know anybody who is looking for employment.

So if you will go back now to the graphic right before the resource center—and it helps you to see that the resource center is central in providing information. Then we move out to what we do with this information and how we distribute it.

I'll begin on the left-hand side where I show aging information consultation and referral. I'll briefly go down our components within that section.

One is the aging connection, which is our public I&R system. That processed over 12,000 calls this past year.

We are under contract with Work Family, which many of you are familiar with, and we service national clients such as IBM, Travellers, AETNA, Arthur Anderson, Mobil Oil, etc. We are under contract with the Partnership Group, who services U.S. Sprint, Social Security Administration, and a number of other companies.

We were funded by Robert Wood Johnson to set up the same kind of employee information consultation system for local corporations which we call ACCESS. We are right now negotiating with a group called Families First, which is an employee benefits association. They will contract with us to do the elder care.

Moving down, employment hotline. We have a contract with Operation Able and the Sears Foundation to set up an older worker employment hotline for corporations. Corporations will call and list their positions available for older workers, and then older workers can call us to access that information.

We are working with AARP and their volunteers as AARP housing counsellors.

And then, finally, we are developing what we call registries of individuals that contract their services like companion aides. Many of the people accessing our system want to know an individual who might be able to provide the service.

Under the special services, I mentioned that we are moving into the direction of working with developers. They want to know where to put highrises and where to put other developments. Students want information. The media wants information. And then other groups, such as elected officials, physicians, etc.

I wanted to make note when we were talking about using physicians that we have had a very difficult time having physicians distribute information for us. It is very, very frustrating. I agree with Senator Abrams that we have a lot of work to do in that area. We have even put information we want to distribute on a prescription pad format hoping that they'll identify with that kind of pulling something off from a pad and handing it to somebody. Not to undermine how they think, but we are getting down to the basics in moving that information.

And then finally, in education and training we are providing training to provider staff. We are providing training to employee member corporations like IBM and Arthur Anderson. They are either coming to our work site or we are going to theirs, and we are going into all sorts of information.

And then, finally, I wanted to mention—I don't think anybody has brought up the critical role that we work with churches. We have developed this resource guide, and we have set up a series of seminars for churches and ask that they send either a staff or a lay person, and then we train that person to be an I&R specialist within their church. We even give them a revised intake form thinking that for many older people that's their only access to information. Then these people are trained. They get a directory. Then they can call our I&R specialist who then answers any specific questions.

We have also done this with the libraries across the region. But we don't distribute this directory unless they go through a training session because we think that if there are too many people out there giving a little bit of misinformation that's certainly not going to serve the purpose.

Another innovative thing we have done is develop this calendar. It is called "Why I Like Older People Calendar." We had that printed by a utility company. The final page in the calendar is our aging connection and how to access information.

We are looking at all sorts of creative ways to distribute information.

I am going to briefly go over—if you move to the graphic that says "County-based aging agency," again we see us just as one part of the cog. We move a lot of our information down into the county level. We provide Title III money that each one of our county-based aging programs has an information and referral staff and they also have a number of case managers on staff.

So I explained basically our regional setup. Now we move down into the county.

An older person needs to only access one number to hook into the whole service system within their particular county.

I want to quickly show you an example of when we get information and what happens to it. I use the 1990 Medicare changes and I show that it comes from AARP, from the National Association of Insurance Companies, and from HCFA. We took information from them. We devised an information alert. We sent that out to providers, community-based organizations, nursing homes, and hospitals. We have over 48 in the region. We send it out to all of the public highrises, private highrises, and subsidized housing, advocacy groups like OWL. Information alerts go out all the time. We number the information alerts and keep them on file.

I have already explained to you how the aging information system works.

We do have a 24-hour hotline that a person can call one number to find out what activities are planned for the region and one number to access what resources information has changed, whatever.

We have briefings. We do a good bit of training. And then, finally, with the special outreach—and I do think that is extremely important because our system is set up not only to give information to those people who call us or find us to get the information; our job is also to go out and provide it. We are working right now with VISTA and an ACTION program and with Social Security Administration. We're calling it "Project Seek." We're really going door to door trying to find the older people that are entitled to benefits and have not received them and to provide that important information.

We have information fairs. We do media specials. We have done week-long media specials on major stations in Atlanta. People call in to get information. And then we do work with programs like Gatekeeper with the utility companies.

Now, finally, my recommendations. Again I see the AAAs as prime pivotal points to receive information and distribute it. I think I briefly explained about the broad responsibility to provide technical assistance far beyond the Older Americans Act network and our role relating to other Federal levels. I think the Act needs to more accurately reflect our responsibilities in this area. Again, like Senator Abrams said, we are moving very much into long-term care, developing private pay systems, and long-range planning.

The next one might be a little bit of a new concept, but as we provide information to the general public, it is not just on where to get home-delivered meals, etc.; it is like where to get insurance assistance to fill out claim forms, where to find somebody to repair their home. What we have had to do is develop service standards so as we list a provider we can be somewhat assured that they are following certain guidelines.

I think the States need to be much more active in giving us direction so before we list a provider they have at least a better understanding of what we expect from this particular service, and then we develop the guidelines for the client so the client better understands that role.

Finally, I believe that we need to develop what I call a working partnership. I think the AAAs in most cases and the State offices do work really well together. I think that we need to add the regional AOA offices. I have been in the field 13 years, and we have yet been gathered together as a Southeast Region to really talk about where we are going and what we need to do. I think we need to move away from an adversarial kind of relationship and into a partnership because we each have our own roles and responsibilities and our own expertise.

Thank you.

[The graphics and charts follow:]

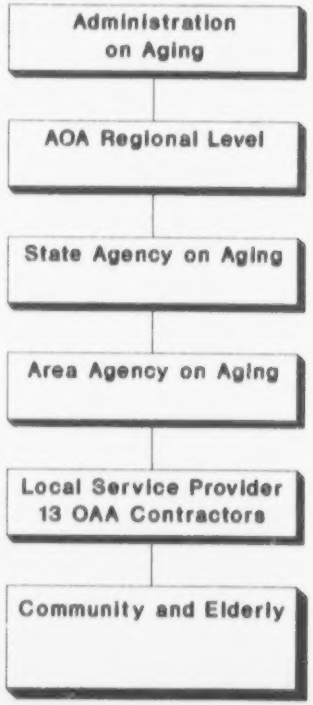
AGING INFORMATION SYSTEMS

U.S. Senate Select Committee on Aging and
the U.S. General Accounting Office's
OAA Reauthorization Workshop

April 19, 1990

Information System

OAA Network



Administration on Aging

AOA Regional Level

State Agency on Aging

Area Agency on Aging

Local Service Provider
13 OAA Contractors

Community and Elderly

Atlanta Regional Commission

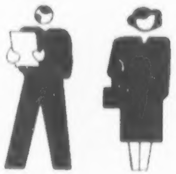
Client Information Collected
Monthly and/or Quarterly

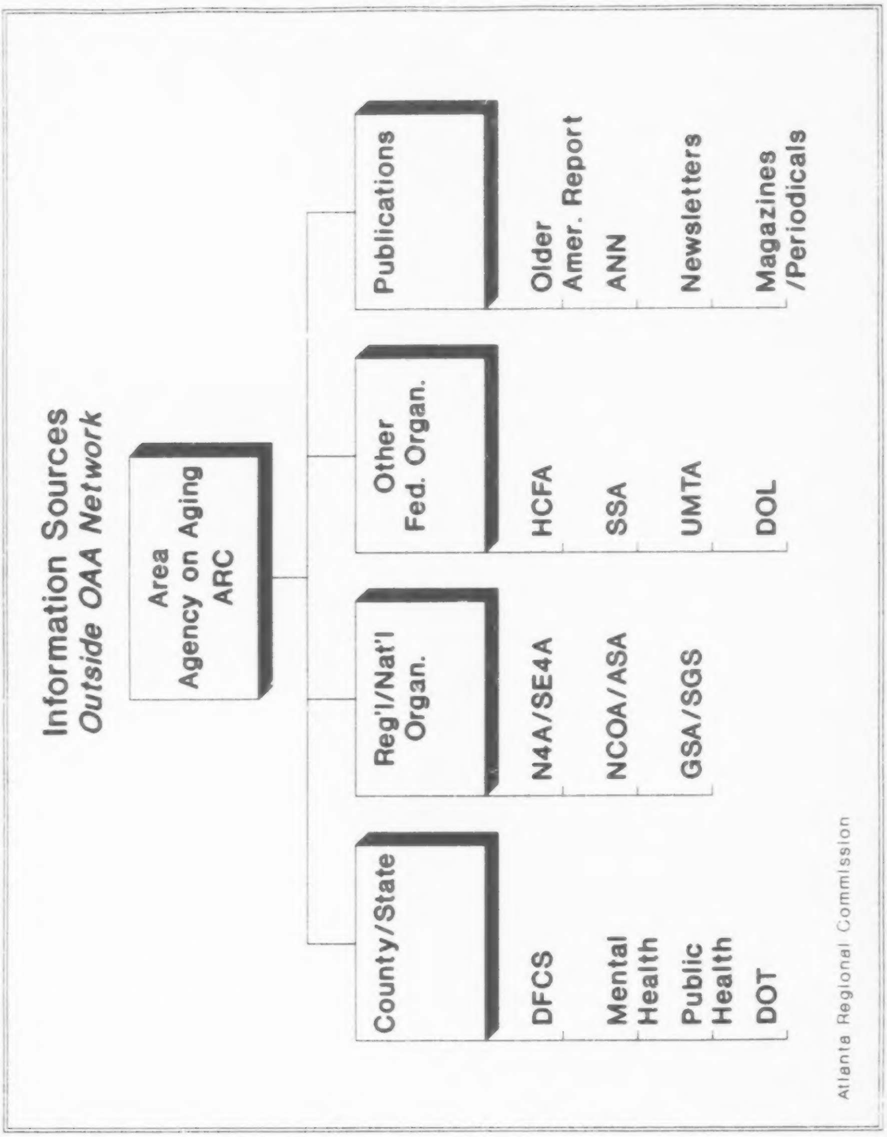
✓ Number of Units Provided

✓ Persons Served:
Number, Race/Origin, Sex, Age, Low Income,
Minority, Greatest Social Need

✓ Waiting Lists

✓ Expenditures



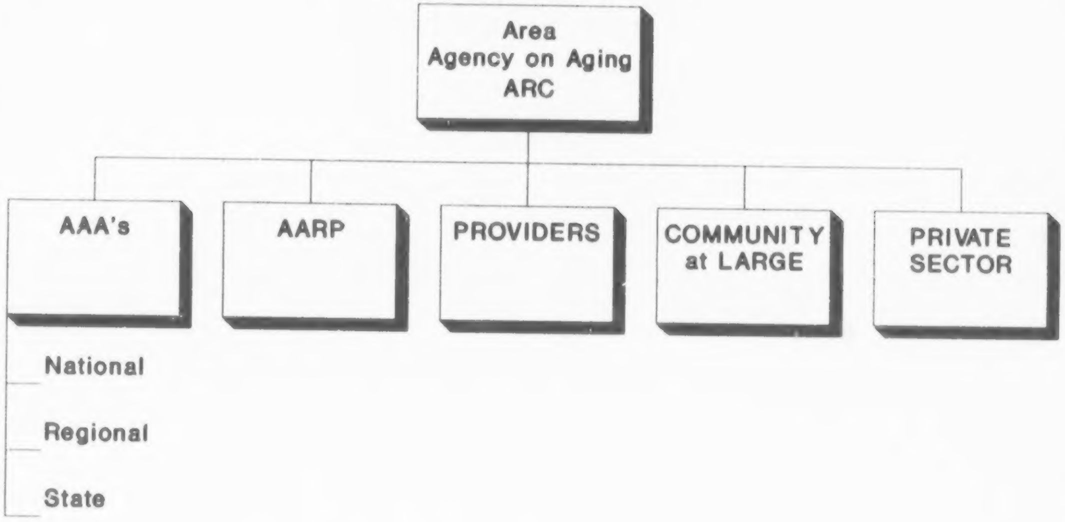


Information Sources
Outside OAA Network

Area Agency on Aging ARC
County/State
DFCS
Mental Health
Public Health
DOT
Reg'l/Nat'l Organ.
N4A/SE4A
NCOA/ASA
GSA/SGS
Other Fed. Organ.
HCFA
SSA
UMTA
DOL
Publications
Older Amer. Report
ANN
Newsletters
Magazines /Periodicals

Atlanta Regional Commission

Information Sources
Outside OAA Network


Area
Agency on Aging
ARC
AAA's
AARP
PROVIDERS
COMMUNITY at LARGE
PRIVATE SECTOR
National
Regional
State

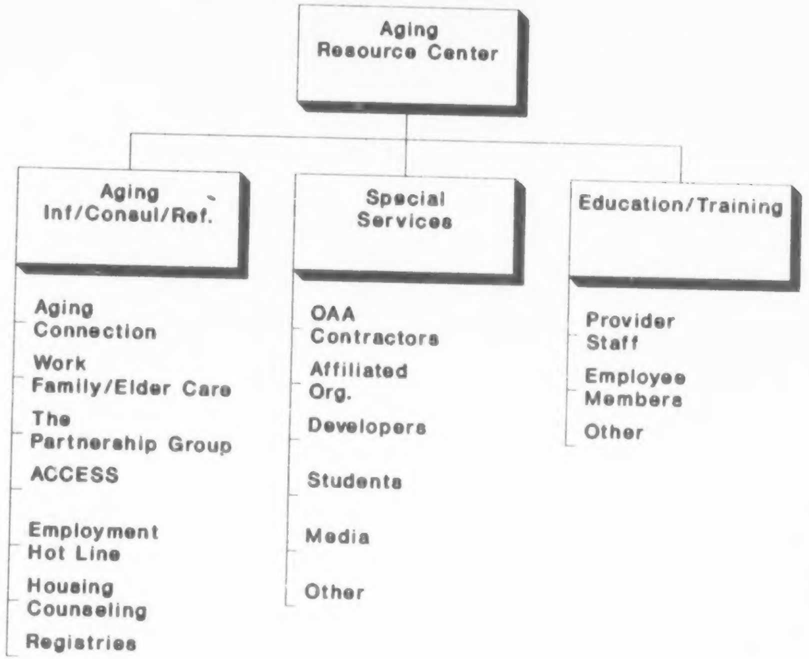
Page Two/Continued

AREA AGENCY ON AGING NETWORK

18 Area Agencies on Aging in Georgia
670 Area Agencies on Aging in the U.S.

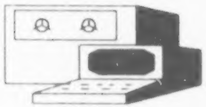
ATLANTA REGIONAL COMMISSION

AAA Information System
Atlanta Regional Commission


Aging Resource Center
Aging Inf/Consul/Ref.
Special Services
Education/Training
Aging Connection
Work Family/Elder Care
The Partnership Group
ACCESS
Employment Hot Line
Housing Counseling
Registries
OAA Contractors
Affiliated Org.
Developers
Students
Media
Other
Provider Staff
Employee Members
Other

Atlanta Regional Commission

ARC'S AGING RESOURCE CENTER



- Provider Base (1500)
  Computerized and Published Listings
- Demographic Data
- Aging Information Library
  Computer Catalogue, Books/Magazines, Program
  Information, Brochure File, Video/Film
- Education and Training Information
- Program Development Packages
- Funding/Grant Information
- Employment Opportunities

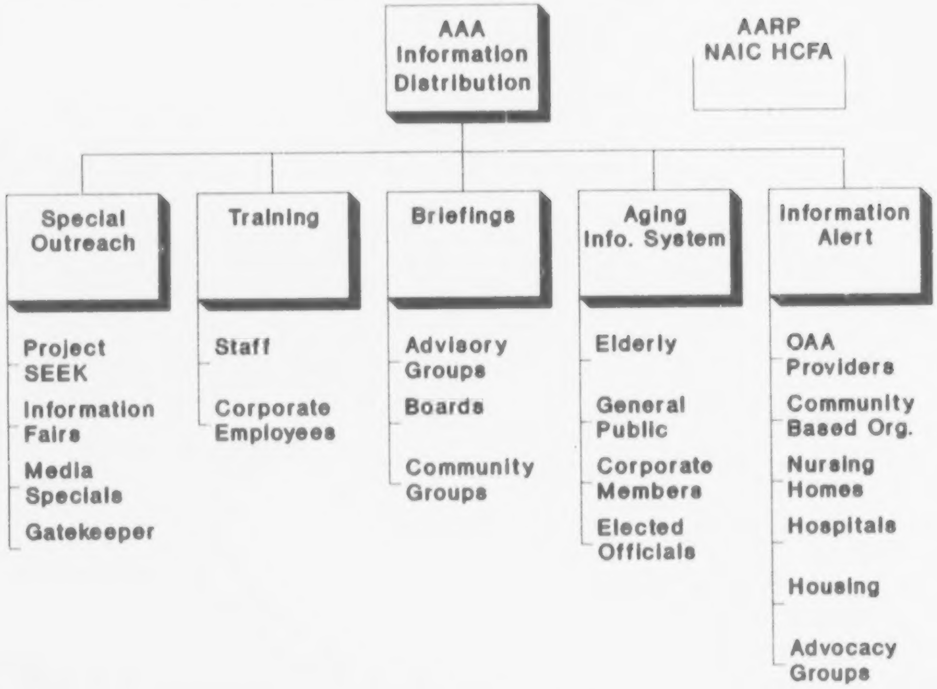
COUNTY BASED AGING AGENCY

Direct Service Provider

- Information and Referral
  "Aging Connection"
- Casemanagement
- Transportation
- Senior Centers
- Congregate Meals
- Home Delivered Meals
- Homemaker Services
- Home Repair/Chore
- Adult Day Care
- Senior Employment
- Volunteer Opportunities
- Leisure and Educational Services

Atlanta Regional Commission

1990 Medicare Changes



- AAA Information Distribution
  - Special Outreach
    - Project SEEK
    - Information Fairs
    - Media Specials
    - Gatekeeper
  - Training
    - Staff
    - Corporate Employees
  - Briefings
    - Advisory Groups
    - Boards
    - Community Groups
  - Aging Info. System
    - Elderly
    - General Public
    - Corporate Members
    - Elected Officials
  - Information Alert
    - OAA Providers
    - Community Based Org.
    - Nursing Homes
    - Hospitals
    - Housing
    - Advocacy Groups

AARP
NAIC HCFA

Atlanta Regional Commission

Recommendations

OAA Reauthorization

✓ **Reflect Broad Responsibility For Technical Assistance**

Program Development of Non-OAA Funded Services,Funding and Resource Development beyond OAA, Private Sector Requirements

✓ **Reflect Broad Role in Relating to Other Federal Level Departments and Divisions**

✓ **Reflect AAA's Changing Role Relative to Long Term Care, Development of Private Pay Services, & Long Range Planning**

✓ **Assign the Development of Service Standards (OAA and Non-OAA) to the States**

✓ **Promote a Working Partnership Between the OAA Levels Recognizing the Roles, Responsibilities, & Expertise of Each**

Atlanta Regional Commission

Mr. SOLOMON. Thank you, Cheryll.

Can I get a copy of your calendar?

Ms. SCHRAMM. You can have this one.

Mr. SOLOMON. Thank you.

Our fourth presenter is James Loftis, Executive Director, Services and Opportunities for Seniors of North Little Rock.

Jim, a graduate of the University of Arkansas at Little Rock, has been actively involved in providing senior services since 1981 when he served as a field representative for the Arkansas Office of Aging and Adult Services. In 1983 he became the Executive Director of the Senior and Children's Services, Inc., which led directly to the establishment of the Services and Opportunities for Seniors, for which he has served as the Executive Director since 1989.

This interesting and intriguing program provides, among other services, the largest single-county Title III meal and transportation program in the State.

Jim?

STATEMENT OF JAMES LOFTIS, SERVICES AND OPPORTUNITIES FOR SENIORS, LITTLE ROCK, AR

Mr. LOFTIS. Thank you.

Let me begin by expressing my gratitude to Senator Pryor and his committee, as well as GAO, for the opportunity to participate in this innovative format.

For those of you all who do not know Senator Pryor, he is one of the great natural resources of our State. We are very proud of him.

In the interest of time, because I know that there are going to be a lot of questions, based on the information that has been presented thus far, I am going to forego my presentation and just read from the statement that I submitted and hopefully allow as much time for questions as possible.

Before discussing information dissemination techniques utilized to reach potential service participants, it must be noted that with current funding levels, which have not increased significantly during the last 5 years, agencies such as this one must be careful not to increase demands for service beyond their ability to provide these services.

This agency's waiting list for home-delivered meals ranges from 50 to 75 persons on a daily basis. The demand for homemaker chore service and transportation services is just as acute.

In terms of actual information distribution, word of mouth has always been and probably will continue to be our most effective outreach tool. Current service levels could be effectively maintained indefinitely based on just the client-initiated calls that we receive.

In addition, relationships have been cultivated with area hospital discharge planners, as well as home health agencies. This has proven to be an effective way to access the homebound elderly.

Finally, service brochures and the scheduling of community-oriented speaking engagements, particularly in churches, are used. The last two techniques have proven for more useful in volunteer recruitment and fundraising than in accessing possible clients.

Special events are advertised in local newspapers, but with service capacity strained, mass media has never been used for client recruitment.

Currently three types of data are collected by this agency. All Title III service providers in Arkansas participate in the management information system originated through the Arkansas Division of Aging and Adult Services. This represents an effort to standardize demographic information collected by service providers and additionally to enable atomization of service reporting and billing. It further allows central office tracking of a client through any particular service throughout the State.

The evolution of this system could have been expedited through solicitation of area agency on aging and provider input, however, it has taken numerous years to fully implement this system.

As a side note, this system has been a lifesaver for programs such as ours because we can now completely do our billing through the use of microcomputers, and this allows us to free up a lot of money that we used to have to spend in administrative costs to put back into services, which is what we are in the business of providing.

In addition to these types of data, service costs must be tracked. Data collected is used to bill the various funding sources for reimbursement. In addition, the demographic information allows for the measurement of progress towards providing services to targeted groups. This tells us how well we are getting to minority participants. It tells us how well we are serving people with greatest economic need and how well we are doing as far as getting people in the greatest social need.

Of course, with limited resources, the value of collecting cost information is self-apparent. In terms of collecting additional information, there is a tremendous need for objective needs assessments not tied directly to services currently available nor to anticipated service development. Additionally, true longitudinal information should be obtained to measure the actual impact of current services.

The aging network could be of great assistance to all service providers by offering information on best practices to contain costs, as well as alternative funding sources. The provision of this type of information would make an excellent first step towards the reestablishment of the partnerships between State units, area agencies, and providers that existed prior to the requirement for competitive bidding for service contracts.

Our experience indicates that tremendous capital expenditure is necessary to develop and operate an aging program, and this, in turn, prohibits an infusion of new bidders, therefore we don't have any competitive bidding.

Further, our experience indicates that competitive bidding makes adversaries out of agencies who need to be cooperating. An area agency cannot effectively provide the information necessary to develop a new service provider and continue to remain objective in the competitive bidding process.

The competitive bidding process discourages existing service providers from cooperating, too, inasmuch as the closest thing to competitive bidding takes place when an existing provider bids on another provider's contract. This creates an environment of mistrust between providers. Under this type of system there is not motivation for providers to communicate, but with the emphasis on unit cost, which is the basis for the whole process, the adversarial relationship between the area agencies and providers is further augmented. The Aging Network must take steps to minimize this adversarial component of contracting.

Because aging programs have been chronically underfunded, providers have been forced to become both skillful managers and expert fundraisers. The Aging Network must continually advocate to keep existing funding, while simultaneously searching for alternative funding for services.

As the elderly population and the demand for services rapidly increases, Congress must recognize the need for increased appropriations for aging programs.

Finally, information will freely flow between all levels of the Aging Network only when these levels act in partnership with each other, and this cannot be legislated. Removal of the obstacles to these partnership can, however. Thank you.

Mr. SOLOMON. Thank you, Jim.

When we first thought about this issue of information flow, it actually came out of the last workshop. As I sat up at the table here listening, I guess I sort of heard two messages. One is that there is not enough information flowing from Point A to Point B. The second message I heard was that we provide so much information to Point A to Point B that nobody knows what is good and what is bad information.

I guess a common theme that has come across at this panel—and maybe I can ask the panel to speak to it--how do you tell the necessary data from the not necessary data? How do you make sure the information flow level is about the right level of information flow and get you out from under the paper and into the programs, itself?

Mr. LOFTIS. I don't think we are required to collect any kind of information that we can't find a use for. A lot of what we end up using—the demographic information that we collect. I don't know how we ever survived before the advent of microcomputers because we can manipulate that data so much better. It is a great fund-raising tool. It turns into great public relations material.

Ms. ABRAMS. When I make a presentation I talk about three important things: demography, demography, and demography. You can't emphasize it enough, even to people in the network. Between now, 1990, and the year 2005 we are going to double the number of over-85's. We don't even talk about the 65-year-olds. Is that useful? You're darn right it is useful. Not only is it useful when you look at the service needs, it is useful when you look at costs.

Within the last year we have seen costs rise about 18 percent—particularly for people who need some health care services. Because the needs are greater—people are aging in place, they are older, they are more handicapped. We are witness to the first time in history when this has happened.

So, yes, you need to look at the data you are collecting. You need to look at how much time you are spending. And you need to see whether you are really using it. That's the problem we find. We've gotten into the habit of just adding on to what we are already doing. Nobody really looks at what happens to information after we collect it. Some of it may not even be useful anymore, and some of it maybe was needed back in another time when you needed some particular information. You may not need it any more. Maybe you needed some information 10 years ago you don't need today.

Mr. SOLOMON. This can be my personal question and answer session. That's okay with me. I have lots of questions to ask yet.

I guess one question that comes to mind, as well, when I was listening to the presentations of not just this panel but the other panel is—I don't know how to say it—maybe the issue of driver versus rider. When I go on a ride I like to be the driver because I am the safest driver in my family. I don't like sitting by the window being the backseat driver.

When I think about the Older Americans Act I think about one of the things Cheryll said in her statement where it used to provide 80 percent of the funds and it is now providing 40 percent of the funds. When I listened to all of the presentations here, people have talked about all the different funding sources, all the different places they gather together the need to get an outreach, if you would, to organizations, not just to elderly people.

I wonder if anybody has any thoughts on what the effect on the Older Americans Act is if it is no longer in the driver seat. Is there something now unique about the Act? The Act might have to be changed because you are now the rider as opposed to the driver.

Bill?

Mr. BECHILL. Well, let me play the devil's advocate. What would the world be like if we had a sunset next year? That isn't a rhetorical question. If you don't like the consequences of that, then you start thinking about what the role is that the Federal Government should have in this field.

I submit that even though—take Howard County, for example, where we have some students placed and I'm very familiar with the budget. Howard County has made great progress in the field of aging, has had strong leadership from a couple of county administrators and their County Council. The Older Americans Act represents now about 20 percent of their total budget.

Is it time to eliminate the Older Americans Act? I think not. I think the reason why Howard County has moved to some degree in that direction was not only the influence of the Act, itself, but the momentum that came from the Act over the years. I think it is very hard for that clearly to be established.

We ought to really be very concerned about a piece of legislation that has been level-funded virtually for the past 7 or 8 years. You speak of demography—Senator Abrams speaks of demography. We are faced with this literal rising sea tide of older population. Those of us who are in this field are very familiar with the demographics of it. We have not kept pace for the past several years and we are entering into a decade.

You have to raise a question on that point. Should there be any Federal responsibility? What should be the Federal responsibility?

I don't have any answers to those kinds of questions, but to me those are the kinds of questions that ought to be coming from people in the field. It really boils down to this: do you want a strong national program? Do you want to highly visible Administration on Aging? Or do you want some other type of an arrangement?

These are issues that are not new to the field of aging, but I submit that this would be a different field if there were not and had not been an Older Americans Act program and an Administration on Aging over the past 25 years.

Ms. **Schramm**. I think the Older Americans Act has provided the base and that where we are now would not have been possible without that base. When I talk about additional moneys coming into the system, the Older Americans Act helped to set that up because you provided the core funding. As county government comes in the private sector, what they are doing is building upon that base. They are helping to pay for home-delivery meals. They are helping to support homemaker services. So it is not that they are going in a totally different direction.

But I do think that since the structure was set up through the Older Americans Act with the State Offices on Aging and AAAs that other departments in the Federal Government should use us. There is no reason why HCFA or Social Security Administration should set up different systems. Why not look at the State offices and the AAAs as the focal point to get the information out and the services.

When you start accessing the national network, I don't know any other service that has such a developed network. A State office can call on another, a AAA can call on another, any many times people need to access information outside their own area. So I think we've got a good system and we need to strengthen it and build upon it.

Ms. **Abrams**. One of the great strengths in Maryland has been the cooperation that exists between the State Office on Aging—and has for about 10 years, I guess—with the other human service delivery departments—Health and Mental Hygiene and Human Resources. It took a long time, and maybe it took the time when there were three women—I'm going to be very sexist and feminist here—three women headed each of the three agencies. We now communicate with each other wonderfully well and have set the model not only for overcoming territorial problems; we sit together at the State level and we sit together at the local level. We have local inter-agency committees. Our committees sit together not only on aging services; we are now sitting together on delivery of services to children which, incidentally, was one of my interests when I was in the Legislature. People are talking to each other. They are overcoming their territorial problems. Aging has done this and I think Aging was the first to do this.

Hopefully we can use Aging now as an example. We have, incidentally, expanded that state inter-agency committee in Maryland to include the Secretary of Transportation, the Secretary of Housing and Community Development, as well as the Secretary of the Department of Economic and Employment Development, because we see the manpower issue, job retraining and employment for older people as central to making older years productive, and also to filling the labor needs of the country in the future.

So yes, there are all kinds of things that come as a result of the Older Americans Act.

Also, the other issues like legal services—how do you provide legal services? Basic levels of service are described in the Older Americans Act. I thank the Act has set the standard, frankly, for delivery of services to the community in a way that other generic services haven't done. Other services have been driven by sponsorship of program, by targeted populations, and by funding sources. We tend to deliver services based on the needs of individuals. I think we really make a very good contribution we are talking about the person out there who is going to get the services and not the category of services that they are getting.

The problem with the medical model, for instance, and Medicaid—and I've got to come back to it because I think it is time that somebody else looked at that—that is not what you are here for, but it is an issue that you ought to look at.

The problem with the medical model is you've got a whole group of medical people involved who really aren't involved with the service needs. They don't identify service needs because they are not skilled in that field.

Doctors and nurses are skilled in providing health care, and health care is not always the need of an older person. Good health may result as a result of your providing, for their other needs: Nutrition for example—you can't have health care without adequate nutrition and without other kinds of supportive services.

So, the Older Americans Act, it seems to me, has been a lightening rod to do this.

Mr. Sugiyama. It has been my experience in Washington State in working with the aging network that it is the envy of other human services programs. Mental Health, Family and Youth Services and other services systems look to the Older Americans Act as their goal, as their model. Where else can you get at the State and at the local level the kind of policy development, planning, service coordination, education, and service delivery? You just can't find that anywhere else.

It is interesting for me, since I have come from outside the aging field 5 years ago, it is light years ahead of other human services program areas. It would be a shame for us to lose that edge and that leadership.

Dr. Al-Ibrahim. I'd just like to respond to a couple of Senator Abrams' remarks. I agree with her completely that there are other issues besides health care. I also agree with her that doctors, or at least many of them, are both ignorant and obstinate.

I also agree with her that doctors, whether in or out of the hospital, are often the first contact for needy clients, and they can often make the difference between a successful referral or otherwise.

Hospitals are of special interest to me because of the high volue of users, because often they identify the people who are the highest users of all kinds of resources, and also because they are the training place for future physicians and health providers.

I think the medical model should not be excluded from the network because what happens, as people are living older and healthier, people live older and then all of the sudden there is this sudden deterioration—the so-called "slippery slope" where often the health care and the social issues and other needs are intertwined.

I also would like to make one last remark, and that is that we hear a lot about process. We don't hear a lot about outcome. We are not going to be able to test or validate things program-by-program, but I think we should make an attempt to validate and evaluate models and see what actually works in terms of outcome.

Mr. SOLOMON. I didn't necessarily see a dichotomy or a difference in what you are saying when I was listening to the Senator or to your response. I think the medical model is part of the aging network. I think what the Senator is saying is that it is not the only part. In fact, the work you have done at Waxter Center is even more proof of that. But you are right about it being a good first point for some people who come into the health care system.

STATEMENT OF PEGGY SHEELER, FAMILY AND CHILDREN'S SERVICES OF CENTRAL MARYLAND

Ms. SHEELER. My name is Peggy Sheeler. I'm from Family and Children's Services of Central Maryland.

I want to get back to the business of not getting any increases in the Older Americans Act. I think in a sense, because the State units and the area agencies have found a way to meet need by other outside resources we have kind of ended up doing that so well we shot ourself in the foot. I think that we should now begin to put greater emphasis on getting those funding levels up.

The other piece of it should be that we shouldn't add any more services if we don't have the fiscal note that is going to pay for it.

Ms. ABRAMS. I would like to respond to that. Region III met one day last week. Some of the area agency directors are here who participated in that meeting. One of the provisions of Title III is called in-home services. Just to give you a little example, the State of Maryland gets an allocation of $75,000. That probably pays for five people, maybe six or eight. On our rolls are over 2,000 people in our program—Coordinated Community Care, which is funded by the State of Maryland to the tune of $5 million.

The need is for about 30,000 people for in-home services paid for by the public, which is 15 times $5 million. So $75 million is the need right now for publicly-funded services in the State of Maryland. This is the long-term care need. These are people you want to keep in the community now so they don't get admitted to a nursing home. We may pay $300 a month now versus $3,000 a month in a nursing home if you're talking about Federal and State funding under Medicaid. That's the population we have to look at, and that's why the Older Americans Act has to look not only at enabling us to do some of the minimal things we do, but meet some of the real needs out there. If you have an entitlement program like Medicaid backing it up, you are going to pick up the cost whether you like it or not. It is there. It is an entitlement.

Mr. BECHILL. For a lot of reasons I don't want to get into the medical model debate, but I'm going to.

A number of people in the field—and I among them—have been very concerned with the tendency in recent years to essentially "medicalize" the Older Americans Act programs. By that I mean they cast the debate around programming at both the Federal and State levels largely in relation to an issue like long-term care.

Now, I think I can talk intelligently about long-term care, but it is not and ought not to be the primary mission of the Older Americans Act.

What we have been doing, I think, is using this Act as a kind of a gigantic pin cushion for problems that ought to be placed on other doorsteps. In other words, if we want to really struggle with the development and design of a long-term care system in the United States, I submit we have to look elsewhere than the Older Americans Act. There are plenty of reasons for that.

That doesn't mean that the Older Americans Act should not be interested in long-term care, but I think its emphasis should be returning more to general and preventive kinds of services. If the Congress is serious about really giving this program major responsibility for large-scale, community-based, long-term care services you are talking not just about a doubling of the appropriations for this Act, you're talking about possibly tripling and quadrupling the appropriations for this Act. That is simply not going to happen under the way this Act or most Federal/State pieces of legislation are financed.

I think that issue ought to be debated on long-term care in the same neighborhood as where Medicare and Medicaid are being debated now, the Pepper Commission report and things of that order. That is where this context needs to belong and not here. We are using this program in many respects—and I feel keenly about it—as a sort of a sop at the moment. We are not going to deliver long-term care services to the entire population through this program unless the Congress decides it wants to, which is a possibility, and then they are going to have to come up with large sums of general revenue financing. I simply do not see that in the cards.

Ms. SCHRAMM. I'd like to also point out that I believe that we have been underfunded for a number of years and that we have to simultaneously not only look for additional public funding, but we've got to change the mindset and we've got to look at private pay.

There are hundreds and hundreds and thousands of people that need home-delivered meals and that need in-home services that can pay for it and they want to pay for it. Our system, in many areas, has not been developed to bill somebody for service. It is amazing how our private, nonprofit agencies—when we first started to look at that and Robert Wood Johnson came in and helped us develop this system, our private, nonprofit agencies just said, "Oh, we couldn't possibly charge for a service." We have to get away from that mindset that we cannot continue to supplement everybody.

Many people want the opportunity to pay and we have to allow within the system to let that happen.

Mr. SOLOMON. I think we have time for just one more question. I know the guy coming up to the microphone. Let me introduce you to him. His name is Doctor Sushil Sharma. Sushil works with me n the General Accounting Office.

As Senator Pryor dedicated these workshops to Senator Matsunaga, the driving force, the person who really was behind all of the hings we are doing here today and the last seminar and the ones to come is Doctor Sharma. No session would be complete without one of his questions.

Dr. SHARMA. Thank you.

The question I want to ask, I just want to somehow bring you back to the issue of information over the network and what this Act can do to enhance the communication flow.

Now, I do know that your program in particular is meeting the intent of the law in the sense that you are trying to reach or meet the needs of a diverse cultural and ethnic groups.

I also verified that within King County area there are other I&A services that are not providing this multi-lingual service that you are providing. I am using this as an example because all metropolitan areas are categorized by very diverse ethnic groups.

I'm going to now relate to an experience in Maryland—I live in Baltimore. I worked in Maryland for many years until I came over here to work. We have the privilege to have both the Baltimore City Commissioner and the Director of the State of Maryland here, and I'm going to confront you with this issue.

In Highlandtown, which is an area which is characterized by ethnic groups, there is a significant number of elderly people living there who do not speak the language. I have personal experience. For that reason, they are excluded from the system.

How come this program which is working so effectively is not being used by other States? Who should be providing such information? What role do you think AOA should be playing in terms of telling you that if you provide such services you really could reach a target population that has not been utilizing services? Would you like to comment in terms of specifically what AOA can do or what States can do?

Ms. ABRAMS. What we can do is to—first, thank you for calling it to our attention. In Highlandtown we have Little Italy, and we have a lot of other ethnic groups. What we are trying to do through our outreach, our SeniorReach program now is to reach down into churches and community groups. We hope we will identify these people and provide them with interpreters. I think maybe we need to provide some additional services for locals who do need interpreters. We hadn't thought about that before, frankly. Barriers for foreign-speaking seniors has not been a major problem to us—not identified—because we have so many small ethnic groups in Baltimore. Baltimore happens to be a very ethnic neighborhood, and usually there are interpreters. I wasn't aware that there is a major problem.

Ms. Neetu Dhawan-Gray is the Director of the Baltimore City Area Agency on Aging. She may wish to add something.

STATEMENT OF NEETU DHAWAN-GRAY, DIRECTOR, BALTIMORE AREA AGENCY ON AGING

Ms. DHAWAN-GRAY. Thank you.

One of the other things I think we need to do is, when we talk about focal points within the Aging Network we often refer to nutrition sites and senior centers. I don't think that is the only way to reach seniors.

In Baltimore City we have Mayor stations, we have multipurpose centers, we have senior highrises. We do have churches, but we also have groups within the hispanic community and the American Indian population that we need to be able to reach out to and ask if they have problems within their work dealing with elderly and how we can help them.

I think we need to get away from the fact that we need to pay for everything. We need to go out and find what is available and then make the linkages happen.

I agree wholeheartedly with Bill Bechill and Senator Abrams' comments earlier that the Older Americans Act sets the framework, but it cannot be the only source of funds that goes into servicing the seniors in the country. I think one way to alleviate that is to elevate the Commissioner on Aging to be an Assistant Secretary so she has the power to look at what is going on with Social Security, Medicare, and make some policy decisions that are much more integrated than at the lower level that she is today.

Mr. SOLOMON. I can't remember when I last had more fun than I have had today. I really have. I thank our panel members so much. I thank the audience.

STATEMENT OF GAIL MARTIN, NATIONAL ASSOCIATION OF MEAL PROGRAMS

Ms. MARTIN. I'd like to make one quick comment on what was discussed. I'm Gail Martin of the National Association of Meal Programs. Our membership represents both congregate and home-delivered and publicly funded and privately funded.

One of the problems—and I'll give you just a typical case study. In Texas a privately funded Meals on Wheels program that gets about 48 percent of its budget from the Federal Older Americans Act and the Area Agency, but the remainder does fundraising and charges and all the other methods of getting funding, was required recently by the State of Texas, because they are tracking people, to track every person that was new to the system—and they do over 1,200 meals a day—for their computer system. That private program had no computer that tied in with theirs, so they requested a computer. The AAA said they would buy them the computer, but gave them no training. It was a new program with a lot of glitches in it.

They then said, "Okay, we only want the new people that have come in since January 1st, but we need this by February 15th." Then they came back and said, "No, no. We want every client that you have had on your list from October of 1989"—all within 6 weeks. They had to hire extra people, put on more overtime work for those that were there—and, by the way, this is a sophisticated program that has nine case managers on the staff, more than most area agencies do.

It ended up costing them money. Therefore, a lot of our members that are privately funded are leery of getting into the AAA and the State unit system because it harms them. It costs them more money and they are required to do more paperwork.

My second point: In a recent survey we found, in answering just this survey, about 25 percent of our members get no Federal dollars at all. They are out there totally surviving on their own. This group, to tie in with what Senator Abrams had said, do not put any numbers into the AAA. The AAA has no reason to ask for their numbers.

I would ask Cheryll, on those 1,500 providers, some of which you do not fund, do you get their data on home delivered meals?

Ms. SCHRAMM [nodding no].

Ms. MARTIN. So those numbers, which we think could be 50 to 100 million meals, are never fed into AOA either because, in other words, in order to get your numbers pushed through area agencies and State units and back to the AOA you either have to get funding from them or ask for USDA assistance. And because of the first case that I spoke about, a lot of these programs don't want to get into that with all of that paperwork and looking at books and everything else that goes on.

So there are a lot of things going on that nobody knows about. Thanks.

Mr. SOLOMON. I suspected as much.

We have two quick announcements before we end.

First, Dick Sugiyama's revised testimony is on the table outside in the hallway. I can't imagine how it was better than the first version, but I guess I'll have to take a look at it.

The second is that if anyone has any question, any additional information, or any comments that you would like to provide on this or any other workshop that we have, just write them to the committee. Send them to Anna Kindermann, Senate Special Committee on Aging, Room G-31, Dirksen Senate Office Building, the ZIP Code is 20510.

With that I would like to just once again—Portia, did you want to say something?

Ms. MITTELMAN. I'm sorry.

Mr. SOLOMON. I'll stay here all day. That's okay. Come on up.

STATEMENT OF PORTIA PORTER MITTELMAN, STAFF DIRECTOR, SENATE SPECIAL COMMITTEE ON AGING

Ms. MITTELMAN. I just wanted everyone to know the Senator was very energized by the discussion he was a part of. He was very sorry that he had to leave, and I apologize, too, that I have been in and out.

But from what I saw and what the Senator saw and the comments that he had in the hall, this has been a wonderful morning. I hope that everyone has had a chance to participate fully. We are going to keep doing this until we get it right.

Mr. SOLOMON. If not, we'll be back in about a month or so.

Ms. MITTELMAN. That's right. So thank you all on behalf of Senator Pryor and Senator Heinz for joining us this morning. And thank you, Jim.

Mr. SOLOMON. Thanks, Portia.

Thanks again.

[Whereupon, at 12:40 p.m., the workshop was concluded.]

REAUTHORIZATION OF THE OLDER AMERICANS ACT

(Workshop No. 3)

THURSDAY, JUNE 28, 1990

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The workshop was held in the Dirksen Senate Office Building, Senator David Pryor presiding.

Staff present: Portia Porter Mittelman, staff director; Christopher Jennings, deputy staff director; John Monahan, professional staff; Anna Kindermann, professional staff; Heather Dreyer, professional staff and David Barnhart, minority professional staff.

OPENING REMARKS BY PORTIA PORTER MITTELMAN, STAFF DIRECTOR, SPECIAL COMMITTEE ON AGING

Ms. MITTELMAN. Good morning, everyone. That was a little too loud, wasn't it? I didn't mean to wake you up quite that way. I'm delighted to have you all here. My name is Portia Mittelman. I'm Staff Director for the majority staff of the Aging Committee, and I really just want to take a few minutes to acknowledge several people who have worked very hard on the event before I turn it over to our moderator, Carol O'Shaughnessy.

First of all, this has truly been a bipartisan effort, and the majority and minority staffs of the Aging Committee have worked very well together to bring to you today an event that we think is going to be a good step toward our discussion about reauthorization for next year.

First of all, I'd like to acknowledge David Barnhart, of Senator Heinz' staff, who is hiding in the back—so you have to stand up, David—and then also several members of the majority staff: Heather Dreyer, who truly has done a wonderful job in putting this all together, Heather is sitting at the front table; also, Bill Benson, many of you know Bill from former lives, Bill is up here in the back; John Monahan, who is also part of our staff, and he's slipped out, I should also acknowledge John's contributions to this event; also, two very special people, truly without whom we wouldn't have been able to put this on.

They are both representatives of GAO, and they're sitting here at the front table, Mr. Jim Solomon and Dr. Sushil Sharma, and I would really like for them both to stand. Jim just had surgery on his feet, so it's hard for him to do. But I really want to pay a special debt to them this morning.

I'd like to turn it over now to Carol O'Shaughnessy, who is a Specialist in social legislation with CRS, to present the morning event, and thank you again for coming.

[The prepared statement of Senator Pryor and Senator Johnston follows:]

STATEMENT OF SENATOR DAVID PRYOR
BEFORE THIRD WORKSHOP CONCERNING
1991 REAUTHORIZATION OF THE OLDER AMERICANS ACT
JUNE 28, 1990

Ladies and gentlemen, thank you very much for attending the third in a series of legislative workshops concerning next year's reauthorization of the Older Americans Act. Today's workshop examines barriers to effective advocacy on behalf of vulnerable senior citizens. To do so, we will focus on the experience of two services authorized under the Older Americans Act (OAA), which have a unique client advocacy mandate -- the long-term care ombudsman and legal assistance.

First, in the 1978 Amendments to the Older Americans Act, Congress required each state to establish a long-term care ombudsman program. Since that time, ombudsman programs have expanded dramatically across the country, providing vital advocacy services to vulnerable residents of nursing homes and board and care facilities. Despite these substantial achievements, the unfortunate fact is that we cannot assure advocacy services to all residents of long-term care facilities who are at risk. I hope today's workshop can explore what steps can be taken in next year's OAA reauthorization to remove obstacles to effective ombudsman advocacy.

In contrast to the ombudsman program, elderly legal services have been provided since the early years of the Older Americans Act. In 1975, Congress recognized the critical importance of legal assistance and declared it a "priority service". However, a longer history has not necessarily assured legal services programs greater success. Organizations and private attorneys providing OAA services face substantial barriers to providing effective legal advocacy in a wide range of important areas, including Social Security, Medicare, and other public benefits, as well as landlord-tenant matters and other consumer issues. I hope that this afternoon's session addressing legal services will examine these problems and stimulate discussion useful for next year's reauthorization.

By focusing on the ombudsman and legal assistance programs in today's workshop, I am not suggesting that these are the only OAA advocacy programs. On the contrary, I believe all members of the Aging Network, from the Administration on Aging to service providers, and all OAA services, from employment counseling to home-delivered meals, serve as advocates for older persons. Looking toward next year's reauthorization of the OAA, I hope we can explore ways to strengthen advocacy efforts undertaken by all persons and organizations providing services to older Americans.

Finally, I wish to thank several people who worked very hard to assure the success of today's workshop. First, I thank our moderator, Carol O'Shaugnessy, of the Congressional Research Service. Carol has written about Older Americans Act services for many years, and she brings her extraordinary knowledge of these programs to today's workshop. Second, I wish to acknowledge the assistance of the General Accounting Office, which has collaborated with the Committee on the entire workshop series. In particular, let me thank Jim Solomon and Sushil Sharma, who as always have made tremendous contributions in organizing today's workshop.

OLDER AMERICANS ACT INFORMATION SHEET

Congress enacted the Older Americans Act (OAA) in 1965 and has reauthorized it Act on ten occasions, most recently in 1987. The Act serves to improve the lives of all older Americans in a variety of areas including income, health, nutrition, employment, and long-term care, among others.

The Act establishes an Administration on Aging (AoA), within the Department of Health and Human Services, to administer the majority of the OAA programs and to act as the chief Federal agency advocate for the elderly. The AoA oversees a network of state and area agencies on aging. The state and area agencies on aging maintain responsibility for funding, coordinating and managing a broad array of service programs and other initiatives for the elderly. In addition to priority areas specified in the Act, local services are supported in response to the needs of individual communities. The OAA also establishes a Federal Council on Aging to advise the President and Congress regarding the needs of the elderly.

State units on aging (SUAs) receive federal funds for implementation of state plans on aging which the AoA has approved. Area agencies on aging (AAA's) then develop and fund services based upon state approved area plans on aging. Primarily through subgrants and contracts with local service providers, AAAs seek to meet the needs of the elderly populations within their jurisdictions. Today there is an "aging network" which includes an aging unit in each state, approximately 670 area agencies on aging, and more than 25,000 local service providers. In addition, the OAA continues to serve as a vehicle for the education and training of thousands in the field of aging.

Congress has scheduled the OAA for reauthorization in 1991. In order to identify key issues that may merit close examination as part of the reauthorization process, the Senate Special Committee on Aging, in collaboration with the U.S. General Accounting Office, is sponsoring a series of workshops in 1990. By obtaining information and opinions from experts in academia, government, advocacy organizations, social services agencies, and other sectors, the key issues for consideration will be identified. In addition, it is expected that legislative changes that may be necessary or desirable as part of the reauthorization process will be suggested.

The third installment in this workshop series will examine two specific OAA services that have a strong advocacy mandate: (1) long-term care ombudsman, and (2) legal assistance. Each service will be considered in a session of approximately two hours. Carol O'Shaughnessy of the Congressional Research Service will serve as the moderator for the discussion.

The first session will examine the long-term care ombudsman. The 1978 Amendments to the Older Americans Act required each state to establish a long-term care ombudsman program. Ombudsmen are to regularly visit nursing home and board and care residents and to assist them in resolving complaints which they may have. Panelists include James Kautz, State Long-Term Care Ombudsman for Louisiana; Anne Kisor, Long-Term Care Ombudsman in Philadelphia; Susan McDonough, State Long-Term Care Ombudsman from the Boston Office of Elderly Affairs; and Roland Hornbostel, State Long-Term Care Ombudsman with the Ohio Department of Aging. They will address the barriers that ombudsmen face in attempting to provide effective advocacy in all long-term care facilities within their jurisdiction.

The second session addresses legal services programs authorized under Title III of the Older Americans Act. States are required to devote an "adequate proportion" of their federal OAA funds to legal services, yet, like the ombudsman program, limited funding poses a significant barrier to effective advocacy. The panelists will address issues that can be considered as part of next year's reauthorization process, such as the use of non-attorney advocates and the types of cases handled by legal services. Panelists will include, Ann Fisher with the Legal Assistance Foundation of Chicago; David Manley, Legal Services of Arkansas; Arnold Wedbee with Evergreen Legal Services in Seattle, Washington; and Penelope Hommel, Executive Director of the Center for Social Gerontology, Inc., Ann Arbor, Michigan.

Following the first session, there will be a 30 minute break (11:30 a.m. to 12:00 p.m.), during which time all in attendance may buy lunch and return to the workshop. From 12:00 p.m. to 12:30 p.m., Elias Cohen of the Community Services Institute in Narbeth, Pennsylvania, will conduct an informal discussion regarding advocacy issues affecting ombudsmen and legal services. After this lunch time break, the second session will begin.

Full and open audience discussion will follow panelists' presentations in each session.

OLDER AMERICANS ACT AUTHORIZATION LEVELS AND APPROPRIATIONS

FISCAL YEARS 1988-91

AUTHORIZATION LEVELS
FY88-91 **[in thousands of dollars]**

Act Title and Services	1988	1989	1990	1991
Title II				
Federal Council on the Aging	$210	$221	$232	$243
Title III				
Grants for State and community programs on aging:				
Supportive services and centers	379,575	398,554	418,481	439,406
Nutrition services	645,130	684,837	727,778	773,017
Congregate	(414,750)	(435,488)	(457,262)	(480,125)
Home Delivered	(79,380)	(83,349)	(87,516)	(91,892)
USDA Commodities	[1](151,000)	[1](166,000)	[1](183,000)	[1](201,000)
In-home services for frail elderly	25,000	26,250	27,563	28,941
Assistance for special needs	[3]25,000	[3]25,000	([3]—[4])	([3]—[4])
Health education and promotion	[3]5,000	([3]—[4])	([3]—[4])	([3]—[4])
Elder abuse prevention	[3]5,000	([3]—[4])	([3]—[4])	([3]—[4])
Long-term care ombudsman	[3]20,000	([3]—[4])	([3]—[4])	([3]—[4])
Outreach for SSI, Medicaid and food stamps	(-[2])	[3]10,000	[3]10,000	([4])
Title IV				
Training, research and discretionary projects and programs	32,790	34,619	36,349	38,167
Home care demonstration projects	(-[2])	[3]2,000	[3]2,000	(-[2])
Ombudsman and advocacy demonstration projects	(-[2])	[3]1,000		(-[2])
Title V				
Community service employment for older Americans	386,715	406,051	426,353	447,671
Title VI				
Grants for Native Americans	[5]13,400	[5]16,265	[5]19,133	[5]22,105
Part A - Indian Program	(12,100)	(14,900)	(17,700)	(20,600)
Part B - Native Hawaiin Program	(1,300)	(1,365)	(1,433)	(1,505)
Title VII				
Older Americans personal health education and training program	(-[6])	(-[6])	(-[6])	(-[6])
Total	[7]**1,538,000**	[7]**1,604,797**	[7]**1,667,889**	[7]**1,749,550**

[1] Public Law 100-175 requires the Secretary of Agriculture to main a reimbursement level of 56.76 cents per meal for fiscal year 1986-91.

[2] Not authorized.

[3] The law requires that total appropriations for programs funded in fiscal year 1987 increase by at least 5 percent over the previous year before appropriations for these new authorizations are made.

[4] Such sums as may be necessary.

[5] The law creates a separate Part B for funds for a Native Hawaiian program. As shown in the table, the law authorizes specific amounts for Part A, the Indian Program, and for Part B. The law further specifies that Part B receive funding only if the total appropriations for title VI exceed the fiscal year 1987 funding level ($7.5 million). Part B will receive the first $250,000 of any appropriations exceeding the fiscal year 1987 level, and half of any increase above the first $250,00 up to the authorized amount.

[6] This title is repealed.

[7] Plus such sums as may be necessary for certain programs.

APPROPRIATIONS
FY88-90 **[in thousands of dollars]**

Act Title and Services	1988	1989	1990 (post sequestration)
Title II			
Federal Council on the Aging	$191	$188	$186
Title III			
Grants for State and community programs on aging:			
Supportive services and centers	268,072	274,352	271,987
Nutrition services	560,611	576,507	574,387
Congregate	(344,664)	(356,668)	(351,924)
Home Delivered	(75,635)	(78,546)	(78,981)
USDA Commodities	(140,312)	(141,293)	(143,482)
In-home services for frail elderly	4,787	4,834	5,756
Assistance for special needs	none	none	none
Health education and promotion	none	none	none
Elder abuse prevention	none	none	none
Long-term care ombudsman	957	988	974
Outreach for SSI, Medicaid and food stamps	none	none	none
Title IV			
Training, research and discretionary projects and programs	23,935	22,173	25,332
Home care demonstration projects	(—)	none	— —
Ombudsman and advocacy demonstration projects	(—)	none	— —
Title V			
Community service employment for older Americans	331,260	343,824	357,013
Title VI			
Grants for Native Americans	7,181	10,710	12,541
Part A - Indian Program	— —	— —	— —
Part B - Native Hawaiin Program	— —	— —	— —
Title VII			
Older Americans personal health education and training program	(—)	(—)	— —
Total	**$1,196,994**	**$1,233,576**	**$1,248,176**

STATEMENT OF SENATOR J. BENNETT JOHNSTON
OLDER AMERICANS ACT WORKSHOP
SENATE SPECIAL COMMITTEE ON AGING
JUNE 28, 1990

Occasionally, very occasionally, it is appropriate for Congress to pat itself on the back, and say, "we certainly did a good job on that". That is how I feel about the Older American Act.

The Older American Act is a textbook case of how to write legislation which does what it is supposed to do. It builds on its strengths, and has no unfortunate side effects. Even so, there are provisions in the law that can be perfected and I am glad the Committee has scheduled this series of workshops to closely evaluate various features of the Act. Today's workshop will concentrate on the long term ombudsman program and legal services.

I am especially pleased that the Committee will be hearing from one of my constituents, Jim Kautz of Baton Rouge. Jim is currently employed by the Governor's Office of Elderly Affairs as the State Long Term Care Ombudsman. Jim and his wife Becky have a long history of service to senior citizens.

I am very proud with the way the Older Americans Act has been implemented in Louisiana. Even before Congress passed this bill, Louisiana had in place the basic framework for the delivery of services. We already had a Council on Aging, and we were ready to charter the parish councils.

Over the years, our parish councils have compiled an astonishing record in the delivery of services. Last year, we provided over 4.8 million meals to more than 100,000 seniors in Louisiana. 100,000 plus seniors receive support services such as transportation, legal services and care in the home. In 21 parishes, we are helping low-income elderly find public sector employment.

Established in 1982 by the Louisiana legislature, the Office of the State Long Term Care Ombudsman is continuing to assist thousands of nursing home residents throughout Louisiana. Louisiana now has 151 ombudsmen that have visited virtually every nursing home in the state, talking to patients and responding to their concerns. The Office of the State Long Term Care Ombudsman has recently coordinated its efforts with the Louisiana Center for the Elderly and Disabled to provide legal assistance to nursing home residents and ombudsmen. Currently over 1,800 attorneys have signed up through the Louisiana Bar Association to provide legal work for the elderly and my latest figures indicate that 1,524 cases were opened during FY1988.

Louisiana is doing a wonderful job in implementing the Older Americans Act. But it still has a long way to go. Next year, Congress will be reauthorizing the Older Americans Act for the 11th time. I hope the information that we receive from these workshops will help us fine-tune to program to be even bigger and better in the future.

STATEMENT OF CAROL O'SHAUGHNESSY, CRS

Ms. O'Shaughnessy. Thank you, Portia.

Welcome to the third in the series of legislative workshops sponsored by the Senate Special Committee on Aging in collaboration with GAO. The subject of today's forum is Barriers to Effective Advocacy: Ombudsman and Legal Services Experience. This morning we're going to focus on ombudsman services and the role of ombudsmen under the Older Americans Act, and this afternoon we're going to focus on legal services.

For both sessions, we have a panel of experts before us who are on the front lines of administering these programs. At noon, we will have a special guest, Dr. Eli Cohen, who will serve as a bridge between the two sessions. At noon time, or actually 11:30, we will break, and we will ask the audience and participants to go downstairs and grab a sandwich and return to the hearing room to hear Dr. Cohen's remarks and to have an informal discussion among ourselves and with Dr. Cohen.

It's important that we break more or less at 11:30 so that you can get your sandwiches. After 12 apparently, the cafeteria is closed to nonstaff members, so we need to get in there before 12.

Our workshop format has been chosen by the Committee in contrast to the traditional hearings format to spark discussion and dialog among you and the panel members. The purpose is to engage in an open discussion, which is really not possible in a hearings format, as you know. Because we have experts from the State and local levels, we really hope that there will be a good interchange among everyone.

Intermixed in our panel presentations will be statements of the members of the Committee as they come in the room to join us, so, as the panel has been told, we may need to interrupt them in midstream, or we may wait until a panel member has finished before the Senator makes his statement. But, as you know, Senators have very busy schedules, and they're going to want to come in and join us for a short time.

Most of you are familiar with the Older Americans Act program, so I'm not going to go into any kind of a detailed discussion. Just a few remarks. As we know, the Act was first enacted in 1965 and this year celebrates its 25th anniversary. Title III, which we'll be talking about this morning, authorizes grants to State and area agencies on aging which are responsible for carrying out many activities. These include the administration of supportive services and nutrition services programs, also acting as advocates on behalf of the elderly, and serving as coordinators of services.

Since original enactment of the Act in 1965, the Title III program has really evolved from simply a funding source for social services to a planning vehicle for comprehensive and coordinative services systems. Title III authorizes a broad range of services in the Act and enumerates at least 20 different services that are authorized. It funds 57 State agencies on aging, 670 area agencies on aging, and over 25,000 local supportive and nutrition services providers.

Just to put the Act's funding in perspective, Title III represents 68 percent of the Act's total 1990 funding of $1.2 billion. The Supportive Services Program under Title III represents 32 percent of total Title III funding and 22 percent of the total Act's funding. Most of the funding under the Act, as you know, is devoted to nutrition services, and I think in your packet you have a detailed funding history going back a few years, so you can peruse that at your leisure.

Before beginning presentations of our panel, I'll just say a few words about the Long-Term Care Ombudsman Program. Recognizing the need to provide residents of long-term care facilities a voice with respect to their care, the basic thrust of the program is to investigate and resolve complaints of nursing home residents. Authority for the program was added to the Act in 1978; however, it originally evolved from demonstration programs that were supported by the Department of Health, Education, and Welfare in the early 1970's.

In the mid- to late-1970's, the Administration on Aging (AOA) expanded the program by awarding demonstration grants in almost all States to support ombudsman activities, and in 1978 Congress amended the Act to require that each State plan on aging include a long-term care ombudsman as part of its efforts. In 1981, the role of the ombudsman was extended to board and care facilities. Prior to that time, the role of the ombudsman was concentrated on skilled nursing facilities and intermediate care facilities. Some fairly significant changes were made in the 1987 amendments of the Act. These included provisions that do a number of things: one, provisions to recognize the role of sub-State ombudsmen, which had not been specifically added into the Act until that time; second, provisions to prohibit conflict of interest in designating ombudsmen by State agencies on aging; and third, a provision to assure that States provide legal counsel to ombudsmen in carrying out their activities and protect them from liability.

Other provisions were added that prohibit interference by nursing home operators in ombudsman functions and prohibit retaliation against ombudsmen in carrying out their duties. AOA data show that across the Nation in 1988, in addition to the Stated programs, there were almost 600 sub-State ombudsmen programs, and nationally about $23 million was devoted to ombudsman activities in 1988, with over half coming from Title III of the Act. Non-Federal funding accounted for about 41 percent.

I think one of the most significant points about this program is the extent to which it relies on volunteers. Again, AOA data show that about 88 percent of the staff involved in the program are volunteers, so recruiting and retaining volunteer ombudsmen is a difficult challenge, and therefore, again, as part of the 1987 amendments, Congress required AOA to review the role and the effectiveness of volunteer ombudsmen and to submit a report to Congress on this subject. This report has just recently been submitted to Congress, about 2 weeks ago, and some of you may want to get a copy of that.

Another issue addressed by the 1987 amendments was the role of ombudsmen in board and care facilities. Because of the large number of these facilities and the prospects for future growth, Congress again required AOA to complete a study of the effectiveness of ombudsmen in board and care, and this report also has been submitted to Congress recently.

So those are just a few words as a historical backdrop, bringing it up to 1987. I'd like to turn now to our panel, and speakers have been asked to keep their remarks to about 7 minutes. They might run over a little bit.

Our first speaker is Jim Kautz, who is the State Long-Term Care Ombudsman with the Louisiana Office of Elderly Affairs. Prior to this position, he was Assistant Director of the Bureau of Research and Development in the Louisiana Department of Health and Human Resources. He is second Vice President of the National Long-Term Care Ombudsman Association and is on the Board of Directors of the Louisiana Aging Network Association.

Jim will talk to us about a very interesting recent survey that he has conducted of State and local ombudsman programs, so at this point I would like to hand the mike over to Jim.

STATEMENT OF JAMES KAUTZ, LONG-TERM CARE OMBUDSMAN

Mr. KAUTZ. I am here to report on a survey that we just completed. I say "we," because, although I put together the figures and wrote the report, which is in your packet, many State ombudsmen participated voluntarily. I think any of you who have ever done a survey would recognize that a response rate of 46 or 47 out of 52 indicates some degree of interest among the respondents, to say the least.

We focused the survey on the capacities of the various State programs to provide the services which they are expected to provide under the Older Americans Act, but we could only focus on a few of those key measures of capacity, which you will see as you read the report.

In a nutshell, the survey showed that the residents of America's nursing homes and board and care homes are served very unequally from State to State by ombudsman programs. In 84 percent of the States, a resident cannot expect to have an ombudsman in his or her facility more than once a month. Indeed, most residents in many States have never seen an ombudsman, and they never will unless they go out of their way to file a complaint.

We first looked at funding, especially at the primary funding source, Title III(b) of the Older Americans Act. Although this Title requires States to establish "effective" long-term care ombudsman programs and to fund them "adequately," neither the Act nor the regulations of the Administration on Aging provide an operational definition of effectiveness or of adequate funding or adequate staffing.

Furthermore, if we measure the responsibility of ombudsmen in terms of the numbers of beds in facilities, we discover rather clearly that Federal funds are not distributed to the States according to a formula that corresponds at all to the responsibilities of the various offices of the State ombudsman.

The formula, as most of you will recall, is based upon population over the age of 60. States, for many different reasons, have more or less beds, more or less nursing home and board and care residents, per population over the age of 60. Consequently, we find that most

States receive between $100 and $150 of Title III(b) funds per long term care facility bed, but four States receive less than $90 and seven States receive over $200.

The spending patterns of the States are very irregular, also. The States spend for ombudsman services between $2.09 per bed and $68.05 per bed. The average expenditure is $11.15 per bed. It is obvious to me that the provision of the Act that States allocate funds adequately in order to provide an effective ombudsman program has been interpreted variously by the States.

We next considered staffing patterns. These were also found to vary widely. The ratio, across the Nation, of beds to full-time-equivalent ombudsmen is one full-time-equivalent per 3,200 beds, but the range is wide: one State provides the one full-time-equivalent ombudsman to every 789 beds, and another one provides one FTE per 21,500 beds. The rest of the States fall somewhere between. Those are employed people; full-time-equivalent employees, not volunteers.

In some States, ombudsman duties include more than the responsibilities prescribed in the Act. In three States, particularly, State unit employees use from one-fifth to two-thirds of their time in nonombudsman activities.

A third focus of our survey was the capacity of programs to be available to residents. We discovered that most States do not provide a constant ombudsman presence in the facilities. Only 16 percent of the States average more than one visit per month to their facilities for purposes of becoming acquainted with the residents, monitoring resident care, informing them of the program services, and simply being there to listen. Board and care homes are visited with considerably less frequency. More than half of the States report no routine visits to board and care homes.

Another measure of capacity to respond to residents and their needs is the location of ombudsmen in proximity to the facilities. It appears that only 13 out of 44 responding States have an authorized ombudsman—either a paid or volunteer—within a 1-hour commute of all facilities in the State.

This is what is. This is what we discovered. The questions that are more difficult to answer are not the questions of what we *are* doing, but of what we *should* be doing and how much it would cost if we did it. We looked at cost figures compared with performance as best we could in the short time available. States in which ombudsmen visit nursing homes at least monthly spend an average of $24.47 per bed. The average cost per bed of having an ombudsman within a 1-hour commute is $17.43.

Based on this kind of analysis, do we have a better formula? Do we have a suggestion for a formula for determining what would be adequate coverage and what would be adequate funding? I cannot say that we do. A more thorough study should be performed before any changes are instituted. Other State ombudsmen and I would be pleased to work with analysts for the Administration on Aging and analysts with Congress to develop a formula of distribution and a formula of standards.

I do have some suggestions as to the parameters of funding. It appears to me that an equitable formula for distributing Federal funds would take into account the base costs required to operate any program as discrete and independent as an ombudsman program must be. That is, some States with small numbers of beds still need a base amount in order to operate. I am "guesstimating" that a base cost is approximately $300,000.

Funding for States will large bed inventories would be less costly per bed. For States with over 10,000 beds, costs would range between $14 for the largest States to $35 per bed for the smaller, depending on local economic conditions. Now, mind you, these levels of funding would not support visits of more than once a month. They would still not support a weekly presence in a nursing home, unless there was an extraordinary amount of volunteer support.

In summary, consideration should be given to the formula for distributing Federal funds and to the establishment of guidelines to the States that more clearly define both the essentials of effective service and the parameters of adequacy.

We recognize the limitations of the data that we have presented. We're pleased to hear that the General Accounting Office and the Inspector General of the Department of Health and Human Services are planning to take long and more detailed looks at ombudsman programs. We know that they are capable of gathering superior data and of performing more sophisticated analyses, but we hope that the questions that we've asked in our survey and the measures of capacity that we have used will assist them in recognizing what those of us who are involved in and committed to ombudsman advocacy are interested in seeing as a part of the planning and decision making process.

Those of us that you will hear talking today have pretty well-based programs. I guess we were asked here because we do. But some of our colleagues across the Nation are hurting. Turnover rates among some ombudsman programs reflect the difficulties they have.

Some ombudsmen know that they are not meeting the most basis and essential levels of service envisioned in the Act. They see the abuse, they see the neglect, they see the suffering, and they know the loneliness in nursing homes, but the best they can do is triage the casualties and treat only a few of the wounded. They await the improvements that can and must be made in the policies established by the Older Americans Act.

[See p. 466 for the prepared statement of James Kautz.]

Ms. O'Shaughnessy. Thank you Jim. I think your study probably gives people a good head start in terms of certain measures of looking at the ombudsman program which have not been available thus far.

Our next speaker is Anne Kisor, who is the Philadelphia Long Term Care Ombudsman. She will speak about the perspective of an ombudsman at the sub-State level. She represents the Coalition of Advocates for the Rights of the Infirmed Elderly and has also worked at the Philadelphia Geriatric Center as the resident social worker.

Anne.

STATEMENT OF ANNE KISOR, LONG-TERM CARE OMBUDSMAN

Ms. Kisor. Thank you. I'm honored to have the opportunity to speak to you today and perhaps give you a little bit of insight into the day to day context of ombudsman work on the local level. The fulfillment of the Older Americans Act mandate to safeguard the health, safety, welfare, and rights of the frail and vulnerable elderly is contingent upon the expansion rather than the limitation of local activities. However, barriers to hiring and recruitment of ombudsman program staff abound.

Impoverished areas, such as Philadelphia, are plagued with a myriad of social problems which trickle down to the nursing home industry. The frustration inherent in the nature of this type of work in this setting, the disappointment of rarely viewing any lasting changes, and low salaries combine to increase turnover rates.

In an era characterized by a do-more-with-less attitude, creative and variant staffing models can offset manpower shortages. Clearly, the proper use of volunteers holds great potential for program growth. Volunteers are known to be the ubiquitous eyes and ears of the ombudsman program. They also embody the spirit of community conscience and involvement, which is critical as long-term care continues to move from a private to a public concern. Finally, volunteers can, with proper training and support, participate with nursing home residents in the actual complaint handling process.

The answers, though, to questions regarding the appropriate use of volunteers require consistent rather then piecemeal approaches. Several States that I'm aware of have grappled with this volunteer-professional balance with successful results. One of the crucial components to success, and I think this is borne out by the sub-State experience, is an extensive screening and training program prior to any onsite visitation, followed with close supervisory oversight and support.

Volunteers range in aptitude, background, and experience; a solid training program lays the common ground. In addition, a proactive and preventative approach is necessary to stem turnover and also to provide consistency for residents.

In Pennsylvania, the 1991–93 State plan on aging considers a more widespread use of volunteers as an issue of priority for future program development. Currently, most local programs now operate with a mix of volunteers and professionals, but not necessarily with uniformity of intent. Hands-on involvement and organizational directives on the State level, as well as standardization and consistency of process, are the key if volunteers are to enter and remain in the realm of complaint handling in an appropriate fashion.

This relationship between the State office ombudsman and local programs extends to other areas beyond the use of volunteers. Both formal and informal policies and procedures color the day-to-day running of the local programs. The relationship between the two is sensitive and vital.

Ideally, leadership on the State level is characterized by several interrelated objectives with the intent to make the ombudsman's job to respond to residents' concerns as reasonable as possible. This can be achieved by setting statewide goals and uniform performance standards, providing ongoing training and support, and by acting as a resource center for Older Americans Act interpretation.

In addition, the State office should be responsible for interstate departmental policy directives and memorandums of understanding. This is crucial, especially in terms of the relationship with the State licensure and certification agency regarding the mutual understanding of roles, operational relationships, and, of course, access to information.

The State office must also be responsible for the timely sharing of appropriate information that is necessary to the duties of the local ombudsman. Policies and procedures should be translated in unambiguous terms through channels at the local level, and sub-State programs are obligated to insist upon accurate and reliable data. This is absolutely essential to the local ombudsman professional obligation to empower residents with current information about laws, regulations and policies.

The State office is also obliged to forestall any policies or procedures that might have unanticipated negative effects upon sub-State programs. Two pertinent examples come to mind. First, it is imperative that the State avoid the creation of a burdensome reporting system. This has a potential negative impact on nursing home residents in terms of resolving concerns in a timely fashion.

Second, the State should not, in general, intervene in professional relationships on the local level. The ombudsman needs to have a fairly loose rein in developing collaborative relationships with other individuals and community agencies. Hence, a great deal of latitude, in concurrence with Administration on Aging directives, is given to the local area on aging in most States in terms of interpreting policy directives.

Conversely, frustration arises on the local level when policy directives are ambiguous. This conflict can manifest in less benign forms where disagreement in role interpretation between the State office, the area agency on aging, and the subcontracting agency is possible. As a result, the local ombudsman can often feel the uncomfortable pull of divergent opinions.

The vague statutory language in the Older Americans Act is a mixed blessing in that it allows for a wide berth in the translation of the term "ombudsman." The debate, then, also ensues as to whether the ombudsman is an impartial mediator or a resident advocate, and experience has told us that clarity of role and function can often be elusive.

The advocacy role is implied, although not specifically word for word stated, in the 1987 amendments to the Act, but it suggests a proactive role that extends significantly beyond the bounds of mediator. This raises several questions, such as what happens when a resident's wishes take the ombudsman beyond the prescribed role in policy? And if one is to truly represent the needs, interests and desires of the resident, is impartiality a realistic goal?

Several States have confronted these issues by enacting enabling legislation to provide a framework for advocacy. Unfortunately, most others continue to be plagued by a lack of consensus and also by the complexity of politics. Vague statutory empowerment seems to give the local ombudsman the ability to investigate, identify problems, make recommendations, but not actually to initiate change.

Pennsylvania is certainly not alone in the struggle to grapple with the mediator-advocate dialectic. There is obviously no quick-fix remedy for this issue. Allowing for discretion in interpretation may undermine the intent of the Act by jeopardizing its full potential and also be erecting additional barriers to effective advocacy. On the other hand, it is not necessarily possible to add specificity without narrowing options for flexibility.

The future visions for the program in terms of compliance with the mandate of the Older Americans Act depend upon, as I said, the expansion rather than the limitation of sub-State activities. It is left open to debate as to whether the initiation of enabling legislation or enhanced local program development will provide the solution.

Conflicts in role interpretation also extend to day-to-day ethical considerations and dilemmas involving the local ombudsman's effective representation of cognitively impaired residents. Questions arise regarding the kind of protection an ombudsman needs to avoid potential breaches of confidentiality and on what basis an ombudsman acts if a resident exhibits consistent memory impairment.

Direct resident involvement in the compliant handling process is not always the norm. Perhaps as close to 50 percent or more nursing home residents have some degree of cognitive impairment, and it is problematic to determine their ability to make decisions consistent with their values. The Act is clear in terms of the resident's right to guide the course of the investigation, yet, applied literally, this can sometimes be impractical.

There are some general principles, however, which guide the ombudsman through these muddy waters. The proposed ombudsman code of ethics forms a good foundational guideline, yet the ombudsman must always be aware of the potential overlap and conflict of professional and personal values. When personal attitudes cloud the ombudsman's ability to conduct an objective assessment, withdrawal from the case is appropriate.

The difficulty begins when the ombudsman is faced with an impaired resident who has not been subjected to a competency hearing and did not have the opportunity or perhaps the foresight to issue some sort of advance directive. A large portion of cases fall into the gray area. As a rule, the ombudsman can attempt to use substituted judgment and avoid the paternalistic trap of best interest standards.

However, it may not be feasible to gain an intimate knowledge of a resident's value system due to both the constraint on the ombudsman in terms of time and resources that it takes to do this properly. Family members are good sources for determination of substituted judgment. In reality, however, many nursing home residents, especially in some inner city areas, do not have the luxury of this type of support.

This is one dilemma that will not spontaneously disappear. Therefore, it is no longer effective to address this issue on a case-by-case basis. The need for a long-term solution becomes amplified with the impending increase in the number of cognitively impaired residents, a group of residents who are particularly vulnerable to a great range of abuses.

Intensive training is needed on the local level, as well as a greater focus upon statewide policies and standards. Ohio and Washington, D.C., for example, have confronted this problem head on through enabling legislation which allows for a greater latitude in things such as access to records and the ability to act as a surrogate decision maker.

This type of specific remedy is absolutely essential if the local ombudsman is to be effective in representing and advocating on behalf of all residents of nursing homes, regardless of their level of impairment. Thank you.

Ms. O'SHAUGHNESSY. Thank you, Anne, for sharing the views from the sub-state ombudsman level.

At this time, we'd like to recognize that Senator Pryor has joined us in the workshop room, and I believe Senator Pryor has some remarks for us.

Senator PRYOR. Carol, first we thank you and all of the speakers this morning. Some of you have come from a long way, and we appreciate all of our participants in the audience.

This is the third in a series of what we call these informal workshops. It is not a hearing, it is not formalized. We're trying this experiment this year to see if we can sort of glean more participation from a broader range of participants. Not necessarily just the organizations that we rely on for information or positions, but most importantly those people who are out there truly in the fields working with these particular programs and with these challenges on a day-by-day basis.

At the end of the seminar today, we would be very, very appreciative if you would make comments, if you want to write them down or if you want to just get up and express yourself, about whether you prefer informality such as this, full audience participation, invitations to anyone to speak or to ask questions, or if you sort of prefer to go back to the old standardized Congressional hearing.

Frankly, I get kind of bored in Congressional hearings, but we want you to feel like this is your workshop and your opportunity and invitation to participate and let us know. In these informal workshops, of course, these are transcribed, we get information, we get the testimony, and also we do feel we get a broader range of participation, and that's what it's all about.

Today, we are dealing with, and I won't be repetitious, we are dealing with two aspects of the authorization issue of the Older Americans Act, which will be next year. I don't think that there is a more important aspect than that of the ombudsman and also those legal services that we must have available for as many residents of long term care facilities as humanly and physically and financially possible.

I think during the authorization debate on the Older Americans Act, I think without question that this is one of the center pieces of that debate, and the information that we glean here, not only from our experts on our panel who are participants and our speakers, but also those who are truly out there, as I've said, on a day-by-day basis, we could not put these workshops on without the help of the General Accounting Office and the very, very fine people that they supply for us to work with us and cooperate in getting information and statistics and also many other kinds of help, and so, Carol, we want to thank you once again, we want to thank all of you who have once again come from a long way to really look at the issues that are going to be, as I say, a central part of that debate.

I think in 1978 that the House and the Senate expressed itself or the Congress expressed itself in pretty uncertain terms that each State—each State—would establish a long-term care ombudsman program. We're trying to see if that program is working. We're trying to see if it has areas that need improving.

We all know that the lack of money is one major hurdle and one major problem, but I think it's very, very necessary before that debate begins next year that we acquire and assimilate this information from those of you who know these programs best.

We want to know it they're working, we want to know what needs there are to make it work better, but I think of equal importance this opportunity of sharing this information, sharing ideas, on an informal basis could be a very, very positive development and certainly could be very constructive in the whole range of debate relating to the Older Americans Act next year.

So let me say that I'm certainly not suggesting that the advocacy programs embodied under the umbrella of the Older Americans Act are the only programs that we're going to be looking at. This is certainly not the case. Like I say, this is one of the areas that we think is most important, and this is an area that we believe will really require the attention and hopefully even a stronger commitment from the Congress as we see more and more people becoming older and older, more and more residents in these particular facilities, and our obligation not only must increase accordingly, but I hope the depth of our commitment will also be there and will be felt in no uncertain terms.

We are in about 5 minutes on the Senate floor going to propound a unanimous consent agreement to the crime bill that will determine whether we're in the next several nights or the next several weeks or what. There are about 18 amendments, I think, that are pending, and one of the key amendments is going to be whether the right to bear arms gives the person a right to carry around a street-sweeper or an AK-47. It seems like we deal with those volatile issues quite often, so I will be having to leave and go be a part of that unanimous consent arrangement, inasmuch as Senator Kassebaum and myself have an amendment that may be brought into that debate.

Let me thank all of you very much, and we appreciate you. Thank you.

Ms. O'SHAUGHNESSY. Thank you, Senator Pryor. We appreciate the fact that you have such a busy schedule.

Before I introduce the next speaker, I'd like to introduce Diane Lifsey. Diane works for Senator John Glenn, who is the former ranking member of the Aging Committee and who authored the Senate version of the long term care legislation that was eventually incorporated into the 1987 amendments.

Our next speaker is Susan McDonough, who is the State Long-Term Care Ombudsman in Massachusetts with the Department of Elder Affairs. Prior to that experience, Susan was the Supervisor of Field Operations for the Massachusetts program and is currently the Regional Director for the New England region of the National Long-Term Care Ombudsman Association.

She is also, as I understand, a licensed nursing home administrator, so she comes with great experience today. She will talk to us about her views on the ombudsman program and, specifically, the Massachusetts program.

STATEMENT OF SUSAN McDONOUGH, LONG-TERM CARE OMBUDSMAN

Ms. McDONOUGH. Hello. It is an honor to be here today, and I want to thank the Senate Special Committee on Aging and Heather Dreyer, in particular, for the opportunity to speak here today. I also welcome the participation of the GAO in organizing this forum.

I've been asked to speak to you about the Massachusetts program and how, in general, we are meeting the mandates of the Older Americans Act. As Carol said, there are programs that have been around since the early 1970's. Massachusetts was one of the first six demonstration programs in the country.

We began developing local programs in Massachusetts in 1977. Today, we have 27 programs and 317 ombudsmen. We visit every one of the 745 nursing and licensed board and care facilities in the Commonwealth on a weekly or biweekly basis. My annual operating budget, both on the State and local level, is $1.8 million, of which $1.6 million is Title III dollars. On the State level, I have four professional staff that assist me in supporting the 27 local ombudsman programs.

I've been asked to discuss how we meet the major mandates of the Older Americans Act in Massachusetts. Regarding complaint resolution, we received and resolved 6,600 complaints last year, of which 88 percent were resolved on the local level.

When we originally developed local programs in Massachusetts, we did so because we needed to enhance the services that we provided. Prior to the initiation of local programs, we received less than 200 complaints a year in the State office.

Regular visitation to long-term care facilities promotes the use of ombudsman services. It is extremely difficult for a frail older person in a nursing home to make a private telephone call or write a letter asking for assistance. It's also particularly difficult, no matter what the age, to remember the unusual word "ombudsman" and find the program.

We developed local programs because we analyzed the difference between the complaints that we received and the cases of jeopardy that were identified by the licensing agent in the mid-1970's. Our complaints did not correlate with most of those jeopardy cases. We see some very major benefits of regular visitation to nursing homes, and although we go once a week, it is not possible for an ombudsman in a 3-hour-a-week visit to see every resident in the facility.

We estimate that approximately 30 residents are seen on each 3-hour visit, so it takes us about a month to make certain that every resident in the facility receives a visit from an ombudsman. In order to make a complaint, I truly believe that residents must be able to trust you, and in order to trust you, they must know you. They must know that if they make a complaint, you will be there to back them up, to protect them from retaliation and to support them.

These are living arrangements, and we were discussing last night at dinner how reluctant each one of us would be to complain about our neighbors or a service that we receive because of the possible types of retaliation that we might experience in our own lives.

A regular presence in a nursing home permits ombudsmen to become the complainants. We can identify the patterns of problems. We do not necessarily need to have a resident who has a specific problem where we would have to use a resident's name. We think that is a key to our success. We very rarely have to use a resident's name, and obviously, would only do so with permission.

We are able to identify patterns in problems and then make general complaints to the facilities without any kind of identification. We are also able to identify complaints and problems before they escalate to crises, and we view that as critical.

In terms of providing services to board and care facilities, we are the only State in the country that provides weekly visitation to the board and care facilities. Services to board and care are difficult to provide and advocacy is difficult for a variety of reasons. One, board and care facilities are less strictly regulated in Massachusetts. They have fewer staffing pattern requirements, they do not often have as detailed plans for social work services, activities, and so forth.

They are, in Massachusetts, inspected irregularly. We require that they are inspected every 2 years. However, there are facilities in Massachusetts that have not seen a licensing or certification person in 5 years. For the most part, the staff is untrained. The residents in many facilities are cognitively impaired. Many residents in Massachusetts have been deinstitutionalized from State mental health hospitals and lack the capacity to advocate on their own behalf. Another concern is unlicensed facilities. Because they look like houses in your neighborhood, and not like the 123-bed brick and mortar nursing home, they are very hard to identify. We do visit those facilities that are licensed on a weekly basis.

Our original policy in Massachusetts was significantly different. When we developed the local programs, we decided to first visit the nursing homes, because they needed the services more, but we quickly reversed that position. We found some very serious cases of neglect and abuse in rest homes, which is what we call our board and care facilities. We essentially learned that these residents really did not have the capacity to advocate on their own behalf, so we now make it a priority to serve the board and care facilities.

Just as an example, in the last year, a case that my staff actually identified and worked to resolve is one where a board and care administrator and owner was sexually molesting the women who were either mentally retarded or mentally disabled in his care and, from what we can tell based on his conviction, had been doing so for a period of at least 3 years.

We also have recently had a case where an owner of a rest home went off and left food for the week for 18 residents which consisted of a pound of hamburger, three bags of rotten carrots, and three boxes of Jello. So although Massachusetts prides itself on providing good quality of care, we do have some very serious instances that we deal with on a regular basis.

I've been asked to describe how we came to have 27 programs and visit the facilities weekly. I believe there is a lack of a mandate within the older Americans Act to require that area agencies operate or fund a program. It says "support" the ombudsman program. We had difficulty trying to attract area agencies on aging to participate in the program and understandably so.

First, there is a conflict on the local level between priorities. Many of the services that Area Agencies on Aging provide are directed to forestalling or eliminating institutionalization, and they believe their money is better spent by focusing on community-based services that prevent or eliminate institutionalization. Plus, there is always the competition for Title III dollars, and they are tight.

We had about half the State covered, or at least half the AAAs in our State providing ombudsman services, in 1983, which was 6 years after we began developing local programs. In 1983, we put a mandate in the area plans that said the AAA had to have a local program or subcontract for an ombudsman program in the area. Today, we require that all area agencies must operate or subcontract a program. We set staffing patterns and supervision requirements. We formally designate programs. We have very clearly articulated standards and policies.

In 1987, we actually set the wages for the program directors on the local level, and, in 1988, we began funding the local programs directly by the State unit on aging. Massachusetts is not unique in this particular instance. I've spoken to seven other States that were identified in Dr. Kautz' survey as providing at least monthly visitation to the facilities in their jurisdiction, and we had some very similar characteristics.

The States include Texas, Mississippi, Louisiana, Oklahoma, California, Ohio, and the District of Columbia. The common characteristics of the model programs are as follows: they do mandate that the area agencies on aging operate local ombudsman programs; they regularly set staffing patterns for supervision on the local level; many of them provide for the development or review local budgets; they all, with one exception, have staff on the State level in addition to the State ombudsman to coordinate local program activities; they have clearly articulated policies; they engage in a regular evaluation process of the local programs and have the capacity to change a contractor or withdraw funds if, they find that the program on the local level isn't doing the job; they all have strong State enabling laws; they use large numbers of volunteers; and they all exist in very supportive environments, although they exist in different types of environments.

For instance, I am housed in a cabinet level agency that is solely dedicated to elderly services. Some of the other programs are umbrella agencies that provide other human services. We all have the support of our respective State unit on aging director. This isn't something that can be legislated, but we do know that this support is critical. You need to know you will be supported if you take a controversial stand, and with the ombudsman program, that is critical. In terms of advocacy, Massachusetts ombudsmen are considered major players in the long-term care policy development in my State. All regulations in Massachusetts for long-term care services are developed with the State ombudsman office's input.

Often we initiate regulatory and legislative changes. Because we are in a cabinet level agency, we are able to file legislation to protect residents. All of the model programs that I spoke of previously believe that they meet this mandate is that we have the time to do the advocacy. You simply cannot provide a presence at interagency meetings, at regulatory forums, at legislative hearings, if you alone at the State level are answering the telephone and responding to people's complaints or are recruiting volunteers.

Regular visitation provides us with a base for our advocacy. We have, unlike all the other State agencies with whom we work, very current information, because our people have been in the facilities and do know what the environments are like. We are able to conduct quick reviews of particular situations. We have a constituency, and we also know individual legislators' constituency problems and problems in their individual nursing homes.

In terms of confidentiality, all ombudsmen truly hold in their heart the mandate for confidentiality of complaints. We in Massachusetts have had several challenges by people seeking access to our files. We have been successful in protecting that confidentiality thus far, but we would like, frankly, to have more strength and more of a mandate.

We do have a problem however. Most States have a similar problem. Our State abuse reporting law is in direct conflict with the Older Americans Act. Most State ombudsmen will make abuse reports if they believe that a resident's life or safety is in danger and will report without the resident's permission for the use of his or her name.

We find that this is a conflict that we all have. I personally would appreciate some clarification or a change that would permit us, in cases where the people's lives are in jeopardy, to act outside the absolute mandate for confidentiality.

In terms of expansion, Jim Kautz' survey indicated that we all have a long way to go. I think it is positively appalling that there are fewer than 10 States in this country that provide at least monthly visitation to the nursing homes in their areas.

Ombudsman programs have been around for a long time, and we have some problems. Many of us are poorly funded, we compete with other important programs for resources, even those of us who are well-funded find that we are in jeopardy because we depend so heavily on Title III dollars. In fact, 95 percent of my funding in Massachusetts is related to Title III, and I anticipate having to cut some services because of the lack of expansion in T-III dollars.

I would suggest before there are any more mandates placed on ombudsmen—I have been in the program since we were also the Older Americans Advocacy Assistance—that we conduct, specifically the GAO and the Inspector General conduct, a review of the existing models in the country.

Many of our colleagues are having a terrible time. Philosophically, they truly want to be the best advocate or service provider for residents in nursing and board and care facilities that they can, but they find themselves carrying out additional mandates imposed by States, specifically to investigate community-based abuse cases or to provide advocacy to people receiving in-home services.

I believe that any expansion of the long-term care ombudsman program should not be at the expense of the residents of nursing homes and board and care facilities. I truly believe that, for the most part, we are the only advocates that many residents of board and care and nursing homes have. They do not commonly get out to access some of the other services that are available, with the possible exception of legal services, which I think have been very supportive in Massachusetts, for residents in board and care and nursing homes.

The ombudsman programs really are the only ones that come and see them and who help them with their problems. I would not be able to recommend anything, frankly, that would diminish that level of service. I appreciate the opportunity to speak today. I do have several recommendations.

I believe the Older Americans Act should define ombudsman services as a priority for area agencies on aging; I believe the Act should specify a separate funding process and level for funds that do not place long-term care ombudsman services in competition with other community-based services; I believe that residents of nursing homes and board and care facilities should have access to all elder services, such as transportation and legal services.

I believe there should be clarification that ombudsmen may disclose the resident's name without consent if the resident's life or safety is in serious danger as a result of abuse or neglect; I believe that there should be a requirement placed on the Administration on Aging to conduct an in-depth study of the effectiveness of the present ombudsman programs and require corrective actions to take place in States found to be out of compliance with the Older Americans Act.

I believe that the Act should describe the necessary components of an ombudsman annual report to ensure that identification of issues has a major focus; I believe the Act should specify what "regular visitation" means and emphasize the importance of services to board and care residents; and I also believe there should be a continued mandate for the National Resource Center. It has been of great value to those of us who operate State ombudsman programs, and I hope that the funding for that will continue. I very much appreciate this opportunity. Thank you.

[The prepared statement of Susan McDonough follows:]

Statement of

Susan McDonough, Massachusetts

State Long Term Care Ombudsman

for

The United States Senate

Special Committee on Aging's

The Third Workshop on the Re-authorization
of the Older Americans Act of 1965
"Barriers to Effective Advocacy: Ombudsman
and Legal Services Experience"

June 28, 1990

MASSACHUSETTS HAS OPERATED AN OMBUDSMAN PROGRAM SINCE 1973, WHEN THE COMMONWEALTH BECAME ONE OF THE FIRST SIX MODEL PROJECTS IN THE COUNTRY. IN 1977, WE BEGAN A VOLUNTEER BASED LOCAL PROGRAM IN SPRINGFIELD, MASSACHUSETTS TO AUGMENT THE SERVICES OF THE STATE OFFICE IN REACHING OUR CONSTITUENTS. TODAY, THERE ARE TWENTY SEVEN LOCAL PROGRAMS, STAFFED BY 317 CERTIFIED OMBUDSMEN WHO VISIT ALL THE 745 NURSING AND REST HOMES (LICENSED BOARD AND CARE FACILITIES) ON A WEEKLY OR BI-WEEKLY BASIS.

ADDITIONALLY, THE MASSACHUSETTS OMBUDSMAN PROGRAM IS CONSIDERED A MAJOR VOICE IN THE DEVELOPMENT OF LONG TERM CARE POLICY LAWS AND REGULATIONS. WE ACTIVELY PARTICIPATE IN CERTIFICATE OF NEED ISSUES AS WELL AS ACT AS A STRONG ADVOCATE FOR THE RIGHTS OF FACILITY-BASED OLDER AND DISABLED PEOPLE ON ALL LEVELS OF GOVERNMENT.

MASSACHUSETTS PROGRAM DESCRIPTION:

THE PRESENT OPERATING BUDGET FOR THE MASSACHUSETTS STATE LONG TERM CARE OMBUDSMAN PROGRAM, ON BOTH THE STATE AND LOCAL LEVEL, IS $1.8 MILLION DOLLARS INCLUDING $1.6 MILLION FEDERAL TITLE III DOLLARS AND STATE FUNDS OF $126,000. ON THE STATE LEVEL, IN ADDITION TO MY POSITION, I HAVE A PROFESSIONAL STAFF OF FOUR, INCLUDING A SUPERVISOR OF FIELD OPERATIONS WHO ORGANIZES ALL THE TECHNICAL ASSISTANCE, MONITORING AND TRAINING OF THE LOCAL STAFF; A LONG TERM CARE SPECIALIST WHOSE PRIMARY FUNCTION IS TO REVIEW ALL PROPOSED LONG TERM CARE POLICY, DEVELOP INNOVATIVE LONG TERM CARE CONCEPTS, AND REVIEW AND COMMENT UPON ALL CERTIFICATE OF NEED APPLICATIONS; A RESEARCH ANALYST WHO REVIEWS ALL LEGAL AND REGULATORY CHANGES AND MANAGES ALL THE COMPLAINTS AND OTHER PROGRAM DATA; AND A REGIONAL SUPERVISOR WHO OVERSEES THE FUNCTIONS OF THE WESTERN MASSACHUSETTS OMBUDSMAN PROGRAM. WE ALSO ARE FORTUNATE ALSO TO POSSESS EXCELLENT ADMINISTRATIVE SUPPORT.

ON THE LOCAL LEVEL, THERE ARE TWENTY-SEVEN PROGRAMS; ALL OF WHICH ARE MANAGED BY A FULL TIME PROGRAM DIRECTOR. IN THE FOURTEEN PROGRAMS WHERE THE NUMBER OF FACILITIES EXCEEDS 30, WE ALSO REQUIRE HALF-TIME ASSISTANT DIRECTORS. THERE ARE 18 STIPENDED OMBUDSMEN, 27 TITLE V SENIOR AIDES AND 226 VOLUNTEERS. THE NUMBER OF WORKERS RANGES FROM 5 TO 22 IN A PROGRAM.

WE VIEW THAT WE HAVE A SUCCESSFUL PROGRAM AND ARE MEETING, AND, IN SOME INSTANCES, EXCEEDING THE MANDATES OF THE PRESENT OLDER AMERICANS ACT AND OUR OWN ENABLING LEGISLATION. I WILL DISCUSS SOME OF THE MAJOR MANDATES.

INVESTIGATION AND RESOLUTION OF COMPLAINTS

CLEARLY, THE ORIGINAL CONCEPT OF THE LONG TERM CARE OMBUDSMAN PROGRAM WAS TO PROVIDE AN AVENUE FOR THE RESOLUTION OF RESIDENTS' COMPLAINTS. IN MANY STATES, THIS MANDATE IS CARRIED OUT BY THE DEVELOPMENT OF LOCAL PROGRAMS WHO EMPLOY VOLUNTEERS TO PROVIDE VISITATION AND COMPLAINT RESOLUTION ADVOCACY TO RESIDENTS OF NURSING AND BOARD AND CARE HOMES.

AS IDENTIFIED IN THE STUDY THAT DR. KAUTZ OF LOUISIANA IS PRESENTING REGARDING OMBUDSMAN PROGRAM CAPACITY, ONLY SEVEN OF A TOTAL OF 44 RESPONDENTS WERE PROVIDING AT LEAST AN AVERAGE MONTHLY VISIT TO THE MAJORITY OF THE NURSING HOMES IN THEIR STATES. ALTHOUGH THE OLDER AMERICANS ACT NEITHER SPECIFIES THE REQUIREMENT FOR REGULAR VISITATION NOR DEFINES IT, NEARLY EVERY STATE OMBUDSMAN PROGRAM DESIRES A PROGRAM THAT PROVIDES WEEKLY VISITS TO THE HOMES. OF THE RESPONDENTS, ONLY MASSACHUSETTS, CALIFORNIA, LOUISIANA, AND THE DISTRICT OF COLUMBIA PROVIDE WEEKLY COVERAGE ON A REGULAR BASIS TO THE MAJORITY OF THE NURSING HOMES.

WHEN WE ESTABLISHED A WEEKLY VISITATION GOAL IN MASSACHUSETTS, WE CONSIDERED SEVERAL THINGS. FIRST, RESPONDING ON A "COMPLAINT ONLY" BASIS SEVERELY LIMITED OLDER, FRAIL AND DISABLED PEOPLE'S ACCESS TO OUR SERVICE. IT IS DIFFICULT TO WRITE A LETTER OR FIND A PRIVATE TELEPHONE IN A NURSING HOME, AND REMEMBERING THE UNUSUAL WORD "OMBUDSMAN" IS A CHALLENGE--NO MATTER WHAT THE AGE. SECOND, DURING THE THREE AND A HALF YEARS WE RESPONDED ON A COMPLAINT ONLY BASIS, OUR COMPLAINTS DID NOT MATCH OR IDENTIFY THE SITUATIONS OF PATIENT JEOPARDY THAT WERE IDENTIFIED THROUGH THE SURVEY PROCESS. TODAY, OMBUDSMEN HAVE BEEN INSTRUMENTAL IN CORRECTING PROBLEMS BEFORE THEY BECOME A CRISIS AND ALERTING THE REGULATORY AGENCIES THAT CRISIS SITUATIONS EXIST.

ANOTHER POINT TO CONSIDER REGARDING THE CONCEPT OF REGULAR VISITATION IS THE QUALITY OF THE VISIT. WE DO NOT EXPECT THAT OMBUDSMEN WILL BE FRIENDLY VISITORS. HOWEVER, WE DO EXPECT THEM TO GIVE THE RESIDENTS ADEQUATE TIME TO EXPLAIN THEIR PROBLEMS. WE ESTIMATE THAT ON EACH VISIT TO A FACILITY, AN OMBUDSMAN (AVERAGE VISIT TO 3 HOURS) MIGHT HAVE CONTACT WITH THIRTY RESIDENTS. IT WOULD THEREFORE TAKE AN OMBUDSMAN APPROXIMATELY FOUR VISITS OR ONE MONTH TO SEE ALL THE RESIDENTS OF A 120 BED HOME AND CONDUCT THE NECESSARY FOLLOW-UP ON COMPLAINTS. WE REQUIRE THAT LOCAL PROGRAMS RECORD THE OMBUDSMAN VISITS IN ORDER TO ENSURE OMBUDSPEOPLE MAKE THE SERVICE AVAILABLE TO ALL THE RESIDENTS IN THE FACILITY.

DEVELOPING LOCAL PROGRAMS

IN ORDER TO PROVIDE REGULAR VISITATION THERE MUST BE LOCAL PROGRAMS. STATE OMBUDSMEN REPORT VARYING SUCCESS IN THE DEVELOPMENT OF LOCAL PROGRAMS. IN LARGE MEASURE, THIS SUCCESS IS DIRECTLY RELATED TO THE INVOLVEMENT OF THE AREA AGENCIES ON AGING. ALTHOUGH THE OLDER AMERICANS ACT REQUIRES THE STATE AGENCY TO CONSIDER THE VIEWS OF THE AREA AGENCIES ON AGING IN PLANNING AND OPERATING THE OMBUDSMAN PROGRAM, AND AOA REGULATIONS REQUIRE AREA AGENCIES ON AGING TO "CONSULT WITH AND SUPPORT THE STATE'S LONG TERM CARE OMBUDSMAN PROGRAM," THERE IS NO CLEAR MANDATE THAT AREA AGENCIES ON AGING MUST PROVIDE OMBUDSMAN SERVICES.

IN MASSACHUSETTS CALIFORNIA, TEXAS, OKLAHOMA AND LOUISIANA (ALL PROVIDING AT LEAST MONTHLY VISITATION), ALL REQUIRE AREA AGENCIES ON AGING, AS PART OF THEIR AREA PLANS, TO OPERATE OR SUBCONTRACT FOR A LOCAL OMBUDSMAN PROGRAM. FURTHER, THESE STATES COMMONLY SET PROFESSIONAL STAFFING PATTERNS, AND HAVE CONTRACTS OR ASSURANCES WITH THE AAA'S THAT SET FORTH VISITATION, CONFIDENTIALITY AND OTHER POLICIES. THE STATE OMBUDSMAN PROGRAMS HAVE SIGNIFICANT INPUT INTO THE DEVELOPMENT OF THE BUDGETS, IF NOT ESTABLISH BUDGETS, FOR THE LOCAL OMBUDSMAN PROGRAMS. OTHER COMMON CHARACTERISTICS OF STATES WHERE THERE ARE REGULAR VISITATION PROGRAMS INCLUDE: ADDITIONAL STAFF AT THE STATE LEVEL TO ESTABLISH AND THEN SUPPORT LOCAL PROGRAMS, PROVIDE FOR RECRUITMENT ASSISTANCE, AND TRAINING NEEDS; THE USE OF LARGE NUMBERS OF VOLUNTEERS WHO ARE SUPERVISED ON THE LOCAL LEVEL BY FULL TIME PAID PROFESSIONAL STAFF; THE PRESENCE OF CLEARLY ARTICULATED POLICIES AND PROCEDURES FOR THE PROGRAM'S OPERATIONS; REQUIREMENTS FOR REGULAR STAFF MEETINGS AND INSERVICE TRAINING FOR THE FIELD STAFF; THE AVAILABILITY OF COMPUTERS TO STORE COMPLAINT AND OTHER PROGRAM INFORMATION; A CONSISTENT AND COMPREHENSIVE EVALUATION SYSTEM; STRONG STATE ENABLING LAWS AND IMMUNITY PROTECTION FOR THE GOOD FAITH PERFORMANCE OF OMBUDSMAN DUTIES.

THE MASSACHUSETTS PROGRAM HAS BEEN EXTREMELY FORTUNATE TO BE HOUSED IN A CABINET LEVEL STATE UNIT ON AGING. LOUISIANA AND TEXAS ARE ALSO BASED IN AN INDEPENDENT STATE UNIT ON AGING. OTHER STATES WITH REGULAR VISITATION PROGRAMS-SUCH AS CALIFORNIA AND OKLAHOMA, ARE HOUSED IN THEIR STATE UNIT ON AGING WHICH ARE PART OF MAJOR HUMAN SERVICES OR UMBRELLA AGENCIES IN THEIR STATES. WITHOUT EXCEPTION, ALL OF THESE STATES HAVE LONG HAD THE FULL SUPPORT OF THE STATE UNITS ON AGING AND HAVE IMMEDIATE

ACCESS TO THE STATE UNIT ON AGING DIRECTOR. THIS SUPPORT HAS BEEN CRITICAL TO THE EXPANSION AND QUALITY OF THE PROGRAM WHEN IT HAS COME UNDER ATTACK OR WHEN INDIVIDUALS, AGENCIES OR GROUPS HAVE ATTEMPTED TO RESTRICT THE ADVOCACY EFFORTS OF THE PROGRAM TO FULLY PROJECT RESIDENTS. THE SUPPORT HAS BEEN PARTICULARLY CRITICAL WHEN THE ADVOCACY INVOLVED OTHER STATE AGENCIES OR WHEN THERE ARE ATTEMPTS TO FORCE THE DISCLOSURE OF CONFIDENTIAL DATA.

THE SUPPORT OF THE CONCEPT OF OMBUDSMAN ADVOCACY BY THE STATE UNIT ON AGING, COMBINED WITH THE MANDATE ON AREA AGENCIES ON AGING TO OPERATE LOCAL PROGRAMS, IS A MAJOR FACTOR IDENTIFIED BY STATES WHERE LOCAL PROGRAM DEVELOPMENT HAS BEEN SLOW OR WHERE THERE ARE NO LOCAL PROGRAMS.

ADVOCACY TO PROMOTE IMPROVED QUALITY OF LIFE, CARE AND ENVIRONMENTS:

IT IS NOT BY COINCIDENCE THAT THE MASSACHUSETTS LONG TERM CARE OMBUDSMAN PROGRAM AND OTHER STRONG STATE PROGRAMS ARE CONSIDERED LEADERS IN THEIR RESPECTIVE STATES IN THE DEVELOPMENT OF LONG TERM CARE POLICIES, LAWS AND REGULATIONS. THE PRESENCE OF REGULAR VISITATION AND ADDITIONAL STATE STAFF ARE KEY TO HAVING A MAJOR POLICY ROLE. FIRST, THE AVAILABILITY OF CURRENT INFORMATION REGARDING FACILITIES BOTH INDIVIDUALLY AND COLLECTIVELY CANNOT BE DUPLICATED BY OTHER AGENCIES AND DOES PROVIDE A STRONG FOUNDATION TO BASE POLICY DIRECTIONS. THE TIME TO ATTEND MEETINGS, WRITE POSITION STATEMENTS, ATTEND HEARINGS, SPEAK BEFORE GROUPS, REVIEW PROPOSED REGULATORY CHANGES AND READ PROFESSIONAL JOURNALS, IS CRITICAL TO ENSURING RESIDENTS' CONCERNS ARE HEARD AND CHANGES INCORPORATED. ALSO, STATE LONG TERM CARE OMBUDSMEN MUST HAVE A BROAD RANGE OF CURRENT KNOWLEDGE IN ALL AREAS OF FACILITY-BASED LONG TERM CARE IN ORDER TO BE EFFECTIVE. IT IS CLEAR FROM MANY STATE OMBUDSMEN THAT THEY BELIEVE THEY ARE NOT MEETING THIS OMBUDSMAN MANDATE FOR ADVOCACY WELL. IT IS DIFFICULT TO BE A MAJOR VOICE WHEN YOU ALONE MUST ANSWER THE PHONE AND RESPOND TO COMPLAINTS. ADDITIONAL MANDATES SUCH AS INVESTIGATING ALL FACILITY-BASED AND COMMUNITY REPORTS OF ELDER ABUSE STRETCH LIMITED STAFF RESOURCES AND MAY IMPEDE THE STATE OMBUDSMAN'S EFFORTS TO BE A VISIBLE, STRONG ADVOCATE FOR THE FACILITY-BASED ELDERLY.

CONFIDENTIALITY OF COMPLAINT, DATA AND DISCLOSURE OF RESIDENT/COMPLAINANT IDENTITY.

MASSACHUSETTS HAS VERY EXPLICIT POLICIES GOVERNING CONFIDENTIALITY OF COMPLAINTS, AND THE RELEASE OF ANY DATA. MOST STATES HAVE DEVELOPED SIMILAR POLICIES. HOWEVER, THERE ARE MANY STATES, INCLUDING MASSACHUSETTS, WHERE THE STATE'S ABUSE AND NEGLECT REPORTING STATUTES PLACE THE OMBUDSMAN STAFF IN DIRECT CONFLICT WITH THE ABSOLUTE MANDATE FOR CONFIDENTIALITY IN OLDER AMERICANS ACT. FOR STATES WHERE REGULAR VISITATION IS ESTABLISHED, THE NUMBER OF INSTANCES WHERE THE CONFLICT ARISES IS SIGNIFICANT AS MORE OMBUDSMEN ARE IN A POSITION TO IDENTIFY CASES OF SUSPECTED ABUSE OR NEGLECT THAT OTHERWISE MIGHT HAVE GONE UNREPORTED.

IN STATES WHERE REGULAR VISITATION TAKES PLACE, STATE OMBUDSMEN REPORT THAT IN SOME OR ALL CASES OF SUSPECTED ABUSE OR NEGLECT OF RESIDENTS OF NURSING OR BOARD AND CARE HOMES, THE OMBUDSMAN WILL RELEASE AN ELDER'S NAME WITHOUT THE INDIVIDUAL'S PERMISSION, PARTICULARLY IN INSTANCES WHERE THE RESIDENT'S LIFE OR SAFETY IS JEOPARDIZED OR WHEN THE RESIDENT APPEARS TO LACK THE CAPACITY TO PROVIDE INFORMED CONSENT. IT IS CLEAR THAT CONGRESS MUST PROVIDE DIRECTION TO THE STATES IN ORDER TO CLARIFY THE POSITION ON ABSOLUTE CONFIDENTIALITY AND THOSE CIRCUMSTANCES, IF ANY, WHEREBY CONFIDENTIALITY MAY BE BREACHED TO PROTECT ELDERS. FOR INSTANCE, THE MANDATE FOR CONFIDENTIALITY COULD BE WAIVED IN LIFE THREATENING CIRCUMSTANCES.

BOARD AND CARE FACILITIES

PROVIDING OMBUDSMAN SERVICES TO THE RESIDENTS OF BOARD AND CARE FACILITIES REPRESENTS A UNIQUE CHALLENGE. IN MOST STATES, THESE FACILITIES, WHEN LICENSED, ARE REGULATED BY DIFFERENT STANDARDS THAN NURSING HOMES, ARE INSPECTED LESS FREQUENTLY AND PROVIDE SIGNIFICANTLY REDUCED SERVICES TO A POPULATION WHICH MAY REQUIRE HIGHER SERVICE NEEDS IN SOME AREAS. ADDITIONALLY, THE OPPORTUNITY TO EXIST AS AN UNLICENSED FACILITY IS MUCH GREATER BECAUSE THESE FACILITIES ARE OFTEN OPERATED IN CONVERTED PRIVATE HOMES AND ARE MUCH LESS USABLE THAN 120 BED BRICK AND MORTAR NURSING HOMES.

IN MASSACHUSETTS, WE ORIGINALLY DIRECTED THE LOCAL STAFF TO COVER THE NURSING HOMES FIRST, AND THEN EXPAND THE SERVICES TO THE BOARD AND CARE FACILITIES. WE HAVE SINCE REVERSED THIS POLICY BECAUSE WE HAVE FOUND THAT CONDITIONS IN THESE FACILITIES ARE OFTEN MUCH WORSE THAN IN NURSING HOMES AND ARE INSPECTED WITH MUCH LESS REGULARITY. TWO EXAMPLES OF CASES HANDLED BY MY STAFF IN THE LAST YEAR INCLUDE A LOCAL OMBUDSMAN PROGRAM IDENTIFYING A BOARD AND CARE OWNER/OPERATOR WHO WAS SEXUALLY MOLESTING THE RETARDED AND MENTALLY DISABLED FEMALE RESIDENTS IN HIS CARE, AND ANOTHER OWNER WHO HAD GONE ON VACATION AND LEFT A POUND OF HAMBURGER AND ROTTEN VEGETABLES AND THREE PACKAGES OF JELLO TO FEED EIGHTEEN RESIDENTS FOR ONE WEEK. IN OTHER STATES, SUCH AS CALIFORNIA, LOUISIANA, OAKLAHOMA AND, THE DISTRICT OF COLUMBIA WHERE NURSING HOMES MAY RECEIVE WEEKLY VISITATION, BOARD AND CARE FACILITIES RECEIVE ONLY MONTHLY OR QUARTERLY VISITS.

BOARD AND CARE OR REST HOMES IN MASSACHUSETTS PROVIDE SERVICES FOR SIGNIFICANTLY IMPAIRED RESIDENTS, PARTICULARLY THOSE WHO HAVE EMOTIONAL, MENTAL OR COGNITIVE IMPAIRMENTS. IN MASSACHUSETTS , MANY REST HOME RESIDENTS WHO WERE "DE-INSTITUTIONALIZED" FROM STATE HOSPITALS, STILL RECEIVE SIGNIFICANT LEVELS OF PSYCHOTROPHIC DRUGS AND RECEIVE CARE IN AN ENVIRONMENT WHERE THERE ARE ONLY FOUR HOURS OF NURSING CARE PROVIDED PER MONTH. OUR STATE DOES LICENSE REST HOMES. HOWEVER, DUE TO STAFFING CUTS IN THE LICENSING AGENCY, FEW OF THE 220 FACILITIES HAVE BEEN INSPECTED ACCORDING TO THE ESTABLISHED TWO YEAR SCHEDULE.

IN FACT, NEARLY ALL OF THE INSPECTIONS IN THE PAST TWELVE MONTHS HAVE BEEN THE RESULT OF OMBUDSMAN COMPLAINTS. THE CONDITIONS THAT HAVE BEEN CITED BY THE LICENSING AGENCY HAVE CONFIRMED OMBUDSMAN REPORTS OF NEGLECT, MISMANAGEMENT AND POOR QUALITY OF LIFE FOR THE RESIDENTS.

FORTUNATELY, THE CONDITIONS HAVE BEEN NOTED BY VARIOUS REGULATORY AGENCIES IN MASSACHUSETTS AND THE STATE OMBUDSMAN PROGRAM, WHO ARE ACTIVELY ENGAGED IN DEVELOPING NEW STANDARDS TO ADEQUATELY MEET THE NEEDS OF THE RESIDENTS.

EXPANSION OF SERVICES TO OTHER CARE SETTINGS.

MANY STATE OMBUDSMEN FEAR THE EXPANSION OF THE OMBUDSMAN SERVICES TO OTHER SETTINGS BECAUSE WE BELIEVE RESIDENTS OF NURSING AND BOARD AND CARE FACILITIES WILL SUFFER A DIMINUTION OF SERVICES. THE RESULTS OF DR. KAUTZ'S SURVEY WERE NOT ENCOURAGING. IF ONLY SEVEN OF 44 STATES RESPONDING PROVIDE AT LEAST QUARTERLY VISITATION TO FACILITIES AFTER MORE THAN TEN YEARS OF OPERATION, IT DOES NOT INDICATE THE SYSTEM, IN GENERAL, IS READY TO EXPAND.

OVER THE YEARS, OMBUDSMAN PROGRAMS HAVE HAD TO COMPETE FOR SCARCE TITLE III DOLLARS AND DESPITE THE FACT THAT OMBUDSMAN SERVICES MAY BE THE ONLY ON-GOING TITLE III PROGRAM THAT IS REGULARLY UTILIZED BY RESIDENTS OF NURSING HOMES, MANY OMBUDSMAN PROGRAMS HAVE NOT BEEN ADEQUATELY FUNDED TO CARRY OUT THE PRESENT MANDATES OF THE OLDER AMERICANS ACT. IN MASSACHUSETTS, DESPITE HAVING ONE OF THE LARGEST ALLOCATIONS OF DOLLARS PER BED IN THE COUNTRY, WE ARE FACED WITH THE PROSPECT OF SERVICE CUTS IN ORDER TO SIMPLY KEEP UP WITH INFLATION IN A TIME WHEN DEMANDS FOR OUR SERVICES ARE ON THE RISE.

IT IS UNDERSTANDABLE THAT MANY STATES ARE RELUCTANT TO ACCEPT NEW FUNDS TIED WITH ADDITIONAL RESPONSIBILITIES. MANY BELIEVE THAT THE INITIAL MANDATES HAVE NOT BEEN ADEQUATELY FUNDED. THE NATIONAL ASSOCIATION OF STATE LONG TERM CARE OMBUDSMAN PROGRAMS HAS DEVELOPED A POSITION PAPER WHICH SETS FORTH THE CONCERNS OF THE ASSOCIATION FOR THE EXPANSION OF MANDATES DURING THIS RE-AUTHORIZATION PERIOD, WHILE ALSO RECOGNIZING THAT VULNERABLE, FRAIL OLDER PEOPLE IN ANY SETTING WOULD BENEFIT BY ADVOCACY AND ASSISTANCE.

AS THE MASSACHUSETTS LONG TERM CARE OMBUDSMAN PROGRAM LOOKS TO ITS ACTIVITIES IN THE NEXT YEAR, WE ANTICIPATE SIGNIFICANT CHALLENGES. DEVELOPING LONG TERM CARE POLICIES AND FACILITY-BASED SERVICES FOR SPECIAL NEEDS POPULATIONS SUCH AS PEOPLE WITH AIDS, HUNTINGTON'S DISEASE, MULTIPLE SCLEROSIS AND HEAD INJURY WILL BE ONE OF OUR PRIORITIES. WE HAVE DISCOVERED THAT IN MANY CASES, YOUNGER PEOPLE WITH DISABILITIES IN NEED OF FACILITY-BASED CARE, LACK AN ADVOCATE TO ENSURE THAT THEIR QUALITY OF LIFE AND CARE ARE ENSURED. ADVOCATING FOR HANDICAPPED ACCESSIBLE AND TRULY "LIVABLE" PHYSICAL PLANT REQUIREMENTS IN EXISTING NURSING AND REST HOMES WILL CONTINUE TO BE A MAJOR FOCUS OF OURS AS WILL THE ON-GOING STRENGTHENING OF THE OMBUDSMAN PROGRAM SERVICES.

Ms. O'SHAUGHNESSY. Thank you, Susan, for your observations.

Our next speaker is Roland Hornbostel, who has been the Ohio State Long-Term Care Ombudsman since 1986, but he has the distinct advantage here in he was also the chief complaint investigator for the Cleveland ombudsman program. Roland is on the Board of the National Citizens Coalition for Nursing Home Reform and is a Vice President of the National Association of State Long-Term Care Ombudsman Programs.

Roland.

STATEMENT OF ROLAND HORNBOSTEL, LONG-TERM CARE OMBUDSMAN

Mr. HORNBOSTEL. Thank you. One clarification: I used to be the Vice President of the National Association of State Ombudsman Programs. I have a more full written statement in your packet, and don't worry, I'm not going to read it to you.

I guess the first statement is the statement itself. You notice that it is Xeroxed on both sides of the page. That is in compliance with the recent Executive Order of Governor Richard Celeste, State of Ohio, to preserve trees and recycle paper. So you see that we bring you something besides acid rain. Ohio does care about the environment.

Let me tell you very briefly a little bit about Ohio's ombudsman network. We are made up to 12 regional programs throughout the State of Ohio. We are relatively well-funded in comparison with other programs. The programs are situated so that the seven smaller programs are operated directly by the area agencies on aging, while the five larger programs are actually contracted services that contract with the area agency to provide ombudsman services.

About 40 percent of the funding for Ohio's regional programs comes from Title III of the older Americans Act, about 40 percent, I am pleased to say, comes from State appropriated dollars—more about that in a moment—and about 20 percent comes from private organizations, church groups, and private individuals who donate to the program.

In our last year, we handled 9,500 complaints filed on behalf of residents of nursing homes and board and care homes in Ohio, and, again, we regard ourselves as being one of the more successful programs.

I'm real glad to be here today, in part because of this forum, but also to express my personal gratitude to the Congress for passing the 1987 Older Americans Act amendments that significantly strengthen the ombudsman program. In Ohio, our experience was that those amendments provided the impetus for a strong ombudsman enabling law that we had proposed continuously for a period of 5 years. It was actually the 1987 amendments to the Older Americans Act that proved to be that little nudge to get us the votes necessary for passage of this important new legislation.

As far as our legislation goes in Ohio, it has only been in effect for the last 2 weeks, so I can't tell you a lot about our implementation of the bill, other than to highlight for you a couple of provisions that others have found intriguing. One, and I guess this a lot of people think is the most intriguing, requires each Ohio nursing facility to pay out of profit $3 per bed for support of the regional ombudsman programs.

Additionally, and somewhat more controversially, is that it does expand our authority to respond to complaints filed on behalf of recipients of community-based long-term care services, and that's the provision that Susan was mentioning at the end of her presentation.

Interestingly enough, Susan and I do not find ourselves very far apart on that particular issue. I, too, am one who does not believe that the ombudsman mandate should be expanded. Without the significant infusion of new dollars necessary to support this service.

Back in 1981, the Older Americans Act expanded the mandate of the ombudsman program to serve residents of board and care facilities. Ten years later, States are still struggling trying to implement that mandate, let alone a new mandate to expand services to people who receive community-based long term care.

Again, Ohio's General Assembly has seen fit to make a specific appropriation, and a rather significant one—$540,000 a year—to support this particular aspect of the program, so it is somewhat advisedly that we have accepted this responsibility. We would not have accepted it without the infusion of new State money to find that expansion.

Besides implementing all of the provisions of the 1987 Older Americans Act amendments, Ohio has struggled in its enabling legislation to put some more meaning into what it means that an ombudsman should be able to pursue administrative and legal remedies on behalf of nursing home residents, and our enabling legislation does two things in that regard.

First of all, it gives ombudsmen standing to bring suits on behalf of residents who feel that their rights are being violated by facilities in Ohio, and, second, it gives the State office, and only the State office, I might add, subpoena powers. It's not something we anticipate that we will use a whole lot, but it is there and is potentially an important mechanism in terms of gathering evidence.

The other thing that I've been asked to talk a little bit about this morning before we open up for questions is the whole issue of legal representation for the ombudsman program. I suppose one reason that I've been asked to sort of serve as a bridge between this morning's panel and this afternoon's panel is the fact that the legal services developer for the Department of Aging actually sits in the ombudsman division and is responsible to me.

Basically, in breaking down the whole issue of legal representation, it seems to me there are three important, discreet areas that need exploration. The first is that, clearly, ombudsmen who are sued in the performance of their duty need legal representation. That doesn't happen very often at all, and in Ohio it has never happened, so that's sort of the easier part of the question, it seems to me, if perhaps the most frightening.

Beyond that, that is clearly a need for ombudsmen to have access to legal advice and counsel on a daily basis and for some of our programs on an hourly basis. That's certainly something that we need to take a little bit more seriously. Finally, there is the whole issue of representing the concerns of residents offensively in litigation. That is, litigation in which the ombudsman is either supporting or actively serving as Plaintiff in litigation as opposed to being put in a defensive posture defending against a particular lawsuit.

There are a variety of ways in which we in Ohio have sought to take seriously the mandate that the State agency provide legal advice, support, and counsel to the regional programs. The first is that in the 1987 amendments, in defining all elements of the office, both staff and volunteers of the State office as well as regional programs, really envisions a situation in which many States' Attorney Generals find themselves compelled to represent the ombudsman program, be it State or local, and that was certainly the opinion of Ohio's Attorney General and Minnesota's Attorney General and some other States that I'm aware of as well.

The problem or barrier here is that the Attorney General's office is frequently outgunned by high price counsel from Washington, D.C., in a lot of cases, that will come in and represent the nursing homes, so an Assistant Attorney General fresh out of law school finds herself or himself at a fairly severe competitive disadvantage.

Second, because of Ohio's peculiar law in which we actually have standing to bring suit on behalf of residents, our Attorney General has now determined that if residents' rights are implicated in the violation and are the gravamen of the legal complaint, then the Attorney General would have to provide offensive representation as well. They're not real happy about that.

Second, the Department of Aging has a contract with private legal counsel, actually a predecessor of mine as State ombudsmen, whom some of you may remember, who obviously knows a lot about the ombudsmen program and is able to provide representation and advice where the Attorney General's ofice will not become involved.

An example of that is where a subpoena is issued to the ombudsman program, and that happens about once a week in Ohio, where the ombudsman is not party to the litigation and therefore does not qualify for the legal representation of the Attorney General's office.

Third, and most importantly, there need to be stronger ties between the ombudsman program and the Title III funded legal services network. The major barrier that I've encountered here in bringing those two vital programs closer together in some kind of working relationship is that neither one of us really understands each other's priorities in terms of services. Priorities in terms of the provision of ombudsman services is something that we really have not talked about nationally but, as you'll see from the paper, I believe to be one of the critical issues as we look toward the 1990s.

We simply have to get away from this notion that the ombudsman program is going to serve everybody, evey time, right at that moment. It's simply not a workable concept anymore. Legal services, on the other hand, have clearly and always, especially the LCS-funded programs, developed priority structures that determine what cases they will take and what they won't take. Therefore, part of the goal of bringing the two organizations into a working relationship is getting each other to understand priorities and identifying those shared priorities.

There are a number of ways the ombudsman program can impact on those priorities that will determine whether a Title III funded legal services program ends up representing nursing home residents. The first is actually for the ombudsman program to become involved in establishing those priorities with the legal services provider. We've had fairly great success and openness on the part of the legal services community in Ohio in allowing that to happen.

The second is to actually mandate a working relationship through some kind of memorandum of understanding or contract between the ombudsman program and the legal services provider in each region. We have not done that in Ohio, but we have encouraged it.

We have encouraged it not because we believe that the ombudsman program is going to sue the legal services program for not providing representation, but it is more a way of setting down in writing what the priorities of the legal services program is and what the priorities of the ombudsman program is so that they share some kind of expectation as to what will happen when a client is referred to either legal services or the ombudsman program for services.

So that's one place where the written agreement is, in fact, very useful. Another approach that we've found very useful is to have cross training of the ombudsman and legal services providers. We're doing it right now on the average of a little bit more than once a year. I would like to do it at least once every 6 months but simply haven't had the staff to do that yet.

Then, there's a lot of cross fertilization between the free-standing ombudsman program and the legal services programs in Ohio by the ombudsman programs involving legal services attorneys, and private bar as well, on their boards of directors and boards of trustees, and us, on the other hand, serving on advisory councils and task forces of the various legal service provider agencies in Ohio.

So all of those have proven to be fairly effective and, I think, creative ways to put some flesh on the mandate in the 1987 Older Americans Act amendments. Like Susan, I have a few recommendations at the end of my paper. Two are fairly modest in scope, and two are, quite frankly, probably more ambitious than we're like to get, but I was always taught that if you don't ask, you don't have any chance of ever receiving anything.

First of all, Susan has already talked about the way in which the confidentiality provisions of the Older Americans Act need to be strengthened or clarified, and I would add a big amen to that. Susan and I are both firm believers, however, that Federal prisons are generally better run and nicer places to be than State prisons, and hence we'll probably come down on the side of violating the Federal laws rather than the State laws. Clearly, there would be some other ways in which we could get around that particular problem so that neither one of us would go to prison and we could keep doing our jobs.

Second, we believe that the back-up centers, and especially the national back-up center for the ombudsman program, should have increased funding to carry out their functions. They have proved to be most helpful in terms of training, in terms of providing good materials, and in terms of helping folks here in Washington understand what the ombudsman program is all about.

But even beyond that, I would extend that also to the national legal services back-up centers, who have provided invaluable support as we go about advocating for nursing home residents. We could not do a lot of these things without funding to these national back-up legal centers who have been very good about not asking us whether we're an ombudsman program or a legal services program but, in fact, providing us with assistance whenever we've called.

The two more ambitious items are to provide matching grants for home care ombudsman activities through the Older Americans Act to encourage State General Assemblies to do as Ohio has done, and that is to fund separately home care ombudsman activities so that we're not faced with the problem of trying to meet additional mandates with no increased revenue. It seems to me something along the lines of a challenge grant would give us a way of doing that.

Then, just overall in terms of funding for the ombudsman programs, and I think Susan was also suggesting this, I believe that we should seriously consider a separate title in the Older Americans Act to fund advocacy services, both ombudsman and legal services.

The reason I think about that is now that I get a chance to influence other aging policy in Ohio aside from just the ombudsman program, I've never yet seen a needs assessment or a funding formula that adequately addresses the needs or concerns of either of these two programs. I think that the flaw is not so much with ombudsman and legal services programs but with the methodology that we use for planning traditional Title III services.

What we are faced with is a very real situation in that we end up competing with other Title III providers. Clearly, now that in Ohio we handle complaints about those other Title III providers, it presents a real conflict of interest for us to have to compete with them for funding. So with that, agree or disagree, I will now sit down, and we can open this up.

[The prepared statement of Ronald Hornbostel follows:]

WRITTEN STATEMENT OF ROLAND HORNBOSTEL

LONG TERM CARE OMBUDSMAN

OHIO DEPARTMENT OF AGING

PREPARED FOR

"BARRIERS TO EFFECTIVE ADVOCACY: OMBUDSMAN AND LEGAL SERVICES EXPERIENCE"

SENATE SPECIAL COMMITTEE ON AGING

JUNE 28, 1990

INTRODUCTION

The following document presents my personal reflections on the Long Term Care Ombudsman Program mandated under the Older Americans Act (OAA). I will attempt to highlight what I consider to be some of the critical issues facing the ombudsman program in the 1990s. Clearly, the 1987 Amendments to the OAA mark the turning point for the ombudsman program nationally. In those amendments, Congress both affirms the critical importance of the ombudsman program while at the same time clearly challenging States to strengthen its own individual program. Before turning to these critical issues, I would like to give some background on myself, the Ohio Ombudsman program, and Ohio's implementation of the 1987 Amendments.

I began my career as the first full time employee of Ohio's first regional ombudsman program in Cleveland in 1977. Since 1986, I have been Ohio's State Long Term Care Ombudsman. As such, I have also had a unique opportunity to shape aging policy in Ohio as we expand community-based long term care services as a member of the Governor's Home and Community Care Council. I have also been privileged to guide Ohio's implementation of the Nursing Home Reform provisions of OBRA '87 as Chair of an interagency task force made up of five state agencies that serve Ohio's long term care residents. Our ombudsman office also contains the legal services developer position mandated by the Older Americans Act.

Ohio's ombudsman network is made up of the state office and twelve regional entities. Of these twelve programs, seven are currently housed under the auspice of an Area Agency on Aging, the other five programs are contracted service providers. One of these five contract agencies also serves as the legal services grantee for its region. Ohio's ombudsman program is relatively well-funded (in relation to ombudsman programs, that is) in that total revenues available to the entire Office of the Long Term Care Ombudsman statewide now approaches two million dollars per year. Approximately 40$ of this funding is derived from federal OAA funds, 40% are State dollars, and 20% are private donations, foundation grants, and the like. Approximately fifty full time professionals serve in the ombudsman program. Additionally, over

200 volunteers contribute their valuable effort to the ombudsman program. In the last year, our ombudsman program statewide handled almost 9500 complaints on behalf of Ohio's long term care facility residents. In other words, while I am fairly biased, I consider ours to be an effective ombudsman program.

OHIO'S IMPLEMENTATION OF THE OAA AMENDMENTS OF 1987

This spring, the Ohio General Assembly passed into Ohio law a comprehensive statute to enable the work of the long term care ombudsman program. One of the primary motivating factors behind this legislation was the support expressed by the U.S. Congress in passing the OAA Amendments of 1987. Ohio's statutory response to these amendments encompasses each issue raised by the OAA Amendments. It creates an Office of the Long Term Care Ombudsman made up of the state office, the twelve regional offices, and the volunteers in the program. The statute uses a designation model much like the relationship that currently exists between a State Unit on Aging and its Area Agencies on Aging.

Ohio's enabling legislation mandates a comprehensive training and testing program for representatives of the ombudsman program, including continuing education requirements. The law creates a rather novel structure to ensure ombudsman access to resident records without violating the rights of the resident to control access to their records. The law also defines the close working relationship that needs to exist between state agencies that monitor and reimburse nursing homes and the ombudsman network.

In some instances, we have merely paraphrased or even copied language from the OAA. In other instances, we have exceeded the Amendments - sometimes in ways that I am sure my colleagues who are ombudsmen in other states disagree with. For example, our legislation clearly extends the benefits of the ombudsman network to recipients of community-based long term care services. (During the debate on the ombudsman bill, the Ohio General Assembly appropriated $540,000 per year to fund the expansion into home care activity). The ombudsman office is given subpoena powers and the right to seek an injunction against any nursing home that violates a resident's rights. Our rationale for these inclusions is the fact that the OAA Amendments require that the ombudsman be able to pursue administrative and legal remedies on behalf of nursing home residents.

One of the greatest unintended benefits of the new Ohio law though is that it has made us clearly take a step back from the day to day firing line of complaints and take a comprehensive look at what we are doing, where we are going, and what is stopping us from achieving our goals. It is this final factor that has fueled my willingness to come before you today to address some of these barriers as we point the ombudsman network toward the future

ISSUES AND BARRIERS (AND SOME OPPORTUNITIES) FACING THE LONG TERM CARE OMBUDSMAN PROGRAM

1. The Role of the Long Term Care Ombudsman.

The primary issue upon which all other ombudsman issues are predicated is determining the appropriate role of the ombudsman. Historically, the long term care ombudsman has been a creature of crisis. The day to day activity of the ombudsman is driven by the complaints she or he handles on behalf of residents. In that sense, the ombudsman program is a reactive program, not a proactive program. The caseloads become so heavy that it becomes difficult if not impossible to consider the future direction that a program should take.

Earlier, I mentioned that in Ohio we have expanded our mandate to serve recipients of community-based long term care services, using a very broad service definition. While that is what we have done in Ohio, I believe that it would be a critical error to mandate that expansion to all states through the OAA. In order to expand the program, new funding must be made available. In Ohio's case we are fortunate that our state legislature made this a priority. Back in 1981, the OAA expanded the ombudsman mandate to include service to residents of board and care facilities. Unfortunately, no new money was made available to fund this expansion. The result is that almost ten years after our mandate was expanded, there are still many state programs that find themselves unable to address board and care issues, let alone home care issues. If new funds are not available for expansion, the inevitable result is that the current effectiveness of the ombudsman program for nursing home residents will be diluted.

At the same time, there is a clear need for advocacy on behalf of those who receive community-based long term care services. Consumer protection should be of utmost importance as we expand the role of community based long term care in addressing the care needs of older Americans. Many states do not license or regulate home health care. I liken the state of community based long term care services to the state of board and care services a decade ago. There are very good community based long term care service providers and there are very bad ones that exploit their clients for financial gain. The problem is: No one is really looking to see which is which. In Ohio, the Medicare certified agencies themselves are clamoring for the state to license all home health agencies because the providers themselves know that the quality of services is so variable. Thus we as ombudsmen face a very real dilemma. We know there is a problem, we know that the ombudsman program has long served as an effective advocate for those who receive long term care services, and yet at the same time we know that we are simply unable to assist everyone who needs our service.

The short term method of dealing with this dilemma, it seems to me, goes back to what I mentioned earlier as a need for the ombudsman program to become more proactive. We need to plan now for how recipients of community based long term care services can also become recipients of advocacy services as well. The ombudsman programs need to be involved in this planning for two key reasons. The first reason is that the nature of long term care is shifting in the United States. Many states are looking for suitable approaches to develop comprehensive systems of community based care that are clearly prefered by older persons in need of long term care. Many states have frozen the growth of institutional long term care and have sought more cost effective ways to serve more people. We as ombudsmen should recognize the inevitability of this trend. Just as the nursing home of the future will be part of each state's comprehensive plan of long term care delivery, so also the ombudsman program must evolve and change to meet these new challenges. The alternative? Nursing homes and ombudsmen who do not face these challenges will become the dinosaurs of long term care in the twenty-first century. The second reason for ombudsman participation as community-based care evolves is more philosophical. Lets face it, the ombudsman program has increased in influence and importance in direct proportion to the expansion of societal concern about how long term care is delivered. It seems to me disingenuous at best to assert that the ombudsman has no role on behalf of recipients of community based long term care services while at the same time benefiting materially from this expanded concern.

At the very least, then, ombudsman programs should engage in planning, teaching, and information sharing with those who also recognize a need for a consumer voice in community based long term care services. There is no easy answer to how we provide advocacy services to consumers with no funding. Therefore, we must seek a harder answer.

Implicit in this discussion is that the ombudsman program which has done so much in exchange for limited funding needs to be careful in defining its direct role in advocacy for older persons. The "ombudsman's disease" that infects almost all of us is to attempt to meet every need that we uncover. In Ohio, a portion of the State ombudsman office has been an enforcement unit with the clear authority and duty to seek monetary civil penalties against nursing homes that violate resident rights. I am trying desperately to get us out of the nursing home enforcement business through additional legislation that should pass this fall. But before you criticize us for doing something that the state survey agencies are supposed to do let me tell you that around the country we now find ombudsmen who provide protective services, we find ombudsmen who witness durable powers of attorney, we find ombudsmen serving as public guardians, ombudsmen who participate directly in determining whether life-sustaining treatment should be discontinued, ombudsmen who train caregivers, and ombudsmen who mediate complaints for hospital residents.

I have come to the not so startling conclusion that the ombudsman's real role when we uncover these unmet needs lies in forcing other systems to do their jobs not in doing their jobs for them. The long term care ombudsman program has not cornered the market on advocacy. In Ohio we have a parallel ombudsman network housed with our Protection and Advocacy system to represent the mentally ill and mentally retarded. I am happy to work with them and equally happy not to be them.

The only proven method to deal with the problems of "role" is through a coordinated planning and reflection process that is somehow mandated. When I first became Ohio's state ombudsman, we began to mandate that each regional office develop a five year plan. Upon reflection, I now think that is probably an unrealistic goal for a program that will always be primarily reactive in nature. It does however seem reasonable that ombudsmen identify issues and develop plans to address these issues on a two to three year planning cycle. While the determination of appropriateness of role is only one planning issue, resolution of this issue highlights several other key issues as well.

2. The Need to Prioritize Ombudsman Activity.

An alternative way to reduce the pressure of service expansion is for the ombudsman programs to begin to prioritize their services. This will seem like heresy to those of us who were brought up with the notion that if a resident has a complaint there must be something the ombudsman can do to fix it. However, prioritization in ombudsman services is no different than the prioritization that is currently encouraged or required in other OAA funded services. The ombudsman program is no more an entitlement program than any other OAA program. From the day of its inception there was never enough money appropriated under the OAA to meet the needs of all older people. Over the years, we have dealt with that issue using several different approaches. At one time, we created the so-called "priority services" under the Act. The current debate while focused in part on the types of services has increasingly moved to a discussion of "targeted" populations. The concepts will increasingly be blended but the goal is the same: To deliver those services most efficiently to the greatest effect.

The ombudsman program can be structured in this same fashion. There are many complaints that we now know, based on both experience and increasingly on more sophisticated data analysis, that are not amenable to effective resolution through the ombudsman process. For example, I really don't expect that Ohio ombudsmen will run out to the nursing home every time they receive an anonymous phone call that the facility is understaffed on weekends. There is little we can do to affect these situations positively. One rationale for this determination legitimately is the one mentioned earlier about an ombudsman not doing someone else's job - in this case the survey agency's - for them. Another rationale is that it is far better that an ombudsman do a bang up job on five cases than a slipshod job on a hundred. Prioritization of activity within the program opens up the possibility that the program can concentrate its efforts where it is most effective, that consumers are not deceived by promises that we know we can't deliver on, and that ombudsmen can now be freer to explore new areas where their intervention may be more effective.

3. Conflict of Interest and the Role of Area Agencies on Aging.

The OAA mandates that the ombudsman program be operated in a fashion that frees it from all conflicts of interest. As the role of the ombudsman expands, however, at some point we are faced with the choice to either deal with conflict of interest from less of a purist attitude than the OAA or we must choose ombudsman offices with little or no affinity for the concerns of older persons. The OAA is simply at a juncture where it is in conflict with itself. Increasingly, there is a need to integrate OAA funded services into a comprehensive network of long term care services while at the same time the OAA funds advocates for those who have problems with these same services.

It seems to me that we can deal productively with conflict of interest by borrowing the methodology currently used by regulators of nursing homes - a methodology based on structure, process, and outcomes. We can do some structural things to deal with conflict of interest. We can prohibit volunteers from volunteering in facilities that they once worked for. We can exclude long term care providers from our governing Boards. At the same time, we can also set into place procedures that deal with the inevitable conflicts that arise. In Ohio, a regional ombudsman in a conflict situation can refer the complaint to the state office for resolution. Regional programs are required to have provisions in their bylaws that address disclosure of conflict. But ultimately, we are most concerned about the outcomes of conflict of interest, i.e. identifying those situations in which an ombudsman has been stopped from doing her or his job. The issue of conflict of interest may best be addressed through ombudsman best practices rather than through the OAA itself, but there may be other legislative options that I haven't considered.

In the context of conflict of interest, the role of the Area Agencies on Aging becomes problematic. Traditionally, in many states the AAAs play a critical role in the ombudsman program. Yet the trend now is to involve the AAAs in the structuring of a comprehensive array of long term care services. As AAAs expand their role into case management and beyond, the day has come or will come shortly where the AAAs will find themselves in a direct conflict of interest with the ombudsman. Added to this dilemma is the fact that most AAAs find it difficult or impossible to effectively monitor the ombudsman program (the same goes for legal services provided under the OAA). The day the OAA amendments of 1987 passed, the role of the AAAs was further diminished. By creating a statewide Office of the Ombudsman and providing for designation of elements of the office directly by the state ombudsman, AAAs lost their most direct contact with the program. Their role is further diminished by the regulations issued by AoA to implement the 1987 amendments. Should a AAA director have access to ombudsman files? What if the complaints are about case management being provided by the AAA? Clearly contracting for provision of ombudsman services is not as easily accomplished as contracting for a home delivered meal. In the interest of furthering national debate on this issue, I will say that I think it time that we come clean in the OAA itself and state that the AAAs have a role in advising the Office of the Ombudsman but that they do not have a role in monitoring the day to day operation of the office.

4. Confidentiality.

Confidentiality of ombudsman records remains a problematic issue for our program. The OAA states that we shall not disclose the names of residents and complainants without written consent or an actual court order. Yet many states have Adult Protective Services laws that mandate the reporting of abuse, neglect, and exploitation by professionals who may also be ombudsmen. Clearly, in many cases the ombudsman is caught in a conflict of two laws. An additional problem is that in certain cases ombudsmen have been threatened with contempt citations for failure to honor subpoenas. I believe it would be wise to add further clarity to the OAA confidentiality provisions.

A second issue in regard to confidentiality is that while clearly it is important to protect the identity of our clients, at the same time it is difficult to obtain resident authorization to intervene on her or his behalf without disclosing the resident's identity. I am not sure that the intent of the OAA was to require that before an ombudsman could intervene on behalf of a resident that written permission be obtained. As a practical matter, the presence of the ombudsman at the nursing home for the purpose of obtaining written authorization from the resident to proceed on the complaint is tantamount to disclosing that resident's identity without permission.

5. Provision of Legal Representation and the Relationship to the OAA Legal Services Community.

Several of the 1987 OAA Amendments speak to the issue of legal representation of ombudsmen. States are to provide both advice and representation to ombudsmen. At the same time, ombudsmen are to be given the ability to pursue administrative and legal remedies. Thus, there is a clear need to link ombudsmen with legal resources both for the purpose of representation in defensive litigation as well as reprsentation in offensive litigation on behalf of residents. There are a variety of valid mechanisms that can be established to provide this needed representation. In Ohio, we have tried all of these in combination because we believe that simply to provide one means of representation fails to address the complexity of the legal situations in which ombudsmen often find themselves.

First, the 1987 Amendments in defining the Office of the Ombudsman to include state and regional programs and staffs both paid and volunteer create a situation which in many states will mandate the involvement of the state's Attorney General in at least defensive situations. The Ohio ombudsman statute in providing that the state ombudsman may petition courts for injunctive relief against nursing homes that violate resident rights creates a limited situation in which the Attorney General must also provide representation in offensive litigation. The major barrier with representation by the Attorney General is that often these attorneys are inexperienced especially when compared to the expensive and experienced legal talent available to nursing homes. This barrier is compounded because the role of the ombudsman is very different from the roles of state employees that the Attorney General has more experience in representing.

Second, the Ohio Department of Aging will provide legal counsel for ombudsmen in those cases where the Attorney General cannot be involved. Examples of this type include legal advice to ombudsmen and appropriately answering subpoenas in cases where the ombudsman is not a party to the action. This is especially critical in that many of the difficult confidentiality issues are raised by these types of subpoenas.

Third, the Title III funded legal services provider network provides a ready source of legal assistance for the ombudsman program. The major barrier I perceive in developing an effective linkage of these two OAA advocacy programs is that we do not understand one another's priorities or even one another's roles. The priority issue is particularly important in the situation where the Title III legal services provider is also an LSC funded program. Each LSC provider establishes priorities for case handling based on the needs of the local community. These priorities differ from locality to locality. In one area, a legal services provider may become involved in guardianship proceedings; in another area, the provider may not see this type of case as a priority at all. One approach to address this barrier is to involve the ombudsman as part of the priority-setting process. Another approach is for the State Unit on Aging to mandate a formal working relationship between the regional ombudsman program and the local legal services provider that specifies in writing the types of cases each will handle (i.e. each program's priorities) as well as the mechanism for referring complaints to one another. While we have not mandated this approach in Ohio, we have encouraged its use - not so much because we expect that ombudsmen and legal services attorneys will be able to sue each other for specific performance of the agreements, but because we believe that if each program understands the priorities, processes, and limitations of the other the barrier to an effective linkeage can be surmounted. A final approach that effectively addresses this barrier is joint training for ombudsmen and legal services attorneys on substantive issues of law affecting nursing home residents.

Fourth, ombudsman programs can ensure that attorneys both from the private and public sectors are adequately represented on governing and policy setting boards. Conversely, ombudsmen can serve effectively on legal services task forces that deal with the legal concerns of older persons and health care issues. The goal of this approach is to create better understanding while at the same time effectively involving one another in the day to day operations of the two programs.

IMPROVING THE OMBUDSMAN PROGRAM THROUGH THE OAA

Many barriers to effective ombudsman activity can be removed or controlled by the individual state ombudsman programs themselves - especially if the necessary time is devoted to strategic planning. The 1987 Amendments to the OAA are a wonderful expression of Congressional support for the ombudsman program nationally. I think it will be some time before states are able to meet all the mandates contained in those amendments due to problems with adequate funding and staffing. However, I also believe that there are several improvements that should be considered during the OAA reauthorization process.

1. **Create a separate title in the OAA for ombudsman and legal services programs.** Those of us who have been involved in OAA programming for some time recognize that these two services are very different than the other services funded under Title III-B of the OAA. In fact, as more states expand ombudsman activity to community based long term care services, the current OAA structure forces the ombudsman program to compete for funds with the services it monitors. Creation of a separate Title acknowledges the inherent conflict between advocacy and other services funded by the OAA.

2. **Matching grants for home care.** It is unrealistic for us to expect that while basic ombudsman services go underfunded that the OAA would create funding for new service categories. However, I think it would be possible to encourage the expansion of the ombudsman program by challenging states to expand the ombudsman mandate with matching state funds. I believe that as the nature of long term care delivery evolves, more states would take advantage of this challenge.

3. **Increase funding of backup centers.** Both the ombudsman resource center, currently a joint effort of the National Association of State Units on Aging and the National Citizens Coalition for Nursing Home Reform, and the various legal services backup centers provide a valuable resource for technical assistance for ombudsman programs. These centers will be even more effective if the funding commitment to them increases. This is perhaps the most cost effective way to increase the programmatic expertise of the ombudsman programs throughout the country.

4. **Strengthen the confidentiality provisions of the OAA.** The issue of whether the OAA overrides elder abuse reporting laws needs to be confronted directly in the OAA language. Additionally, language should be added to clarify that the ombudsman program will not disclose information identifying clients of the program

pursuant to a mere subpoena. In Ohio, we have extended these confidentiality provisions to those who cooperate with the office in investigating and resolving complaints.

Ms. O'SHAUGHNESSY. Thank you, Roland, for your perspectives.

The committee has two jobs for you now. One is, of course, to think of questions and to open dialog with our experts from these various States and localities. Second, Senator Pryor specifically asked if you would make some comments on paper about the workshop format as a way to bring out issues on these two subjects in distinction with the hearings format. He specifically wants to see what you think about this area.

Before you begin questions, we have about a half-hour for dialog, I'll just pick out a few main themes that were brought out by our panelists to sort of jog some discussion. People raised the issue of the need for regular visitation to develop relationships with nursing home administrators and with the residents. I think Anne phrased it very nicely when she talked about a framework for advocacy. I think this kind of visitation probably gives the ombudsman a framework for advocacy.

People talked about the difficulties in staffing and funding, about the need to set staffing patterns. People talked about the conflicts in the confidentiality requirements. Some States have mandatory reporting for elder abuse issues; the Older Americans Act requires confidentiality.

Roland and Susan both brought up the questions about what to do about expansion of the role of ombudsman in home care. I'd be interested in everyone else's perspective on that. Someone brought up the point about a need for a strong State mandate for the ombudsman program.

Other issues were a need for data on ombudsman program, although someone else said—I think it was either Susan or Anne talked about let's not have burdensome reporting requirements from the States. Roland said the role of the ombudsman is to make other systems do their jobs. I think that's nicely phrased. Also, an issue was brought up about the importance of legal protection for the ombudsman.

So these are some of the points, obviously, not everything that was mentioned. At this point, we're going to open it up for discussion. Does anyone in the audience have something?

STATEMENT OF MR. SCHULDER, NATIONAL COUNCIL ON AGING

Mr. SCHULDER. I'm with the National Council on Aging, and any of you or all of you, I didn't hear very much about the volunteer ombudsman in your programs, how the problems and the pulses of utilizing volunteers, I heard almost nothing, and how crucial are they to your program, and in terms of the Older Americans Act reauthorization what should be done about them.

Mr. KAUTZ. First, our study didn't get into volunteer numbers, simply because we didn't have the luxury of time to collect that data, and we didn't want to burden everybody else with extra reporting.

We have an experience in Louisiana of trying very hard over many years to involve volunteers; trying many methods. We have achieved some success in some areas, mostly urban areas. In rural areas, the involvement of volunteers becomes difficult for a number of reasons, not the least of which is that an ombudsman has to be open to conflict. I mean, the person who takes this job has to be able to get involved with some pretty heavy give and take which may relate very negatively to the major employer in a small town, namely, the nursing home.

A lot of folks in small town environments are not willing to get into that. They'll visit and help out in the nursing homes, so we've found other roles for volunteers besides the direct ombudsman role. When I heard the figure earlier that 88 percent of the personnel within the program are volunteers, I thought that there ought to be a proviso here; there ought to be an explanation.

For instance, in Louisiana, we have two types of roles for volunteers. One we call the long-term care visitor. These are not authorized ombudsmen. They do not have the training nor the authority to resolve complaints of any nature, of any level of intensity. They are eyes and ears for ombudsmen, they help provide visits and contact with the outside world for the residents, but they are not ombudsmen.

Then we have ombudsmen who are certified, authorized as the Act specifies, to do ombudsman work. I suspect that the "88 percent" figure includes those who are not authorized, certified ombudsmen. They are folks with 5, 10, 12 hours of training who go in as friendly visitors.

The role of the volunteer is extremely important, and it is successful in many places. But our experience is—and I think my colleagues on the panel have included in their papers some comments along these lines—that it takes a great amount of good professional support to keep volunteers going, to keep them from turning over rather rapidly.

They have to be able to get answers at the end of a phone line. They have to get good back-up. They have to have training. The training has to be provided not only in the daytime when most of us work, but also in the evenings when the volunteers are off work—unless they are retired volunteers.

So there is a big cost. Volunteers are expensive, but they ain't cheap. If support is not there, you'd best not drag these people into what is a very difficult, demanding job and leave them out there hanging.

Ms. O'Shaughnessy. I believe we have someone else who would like to make some comments about the volunteer ombudsman.

STATEMENT OF JOHN McMANNIS, ARLINGTON, VA, VOLUNTEER OMBUDSMAN

Mr. McMannis. Congratulations to the gentleman from the National Council on Aging for his remarks. I'm a volunteer ombudsman. I'm not paid by anybody, proprietary, nursing home, voluntary, or nothing. I'm just a trained volunteer, and I'm here thanks to the NCOA saying there was such a meeting.

As a result of listening to the discussions and the good Senator, I wrote down several ideas that I would like to share with you. To me, they're important, as a professional social worker, because I think they're missing.

The first is, of all the things that have been said here today, including the writing that I haven't had a chance to read in that pack yet, there has been very little, if any, reference to community involvement in what you do. You have an umbilical cord that's tied to whatever Title III is. I've heard that over and over ad nauseum here that's so important to you.

But I'm thinking where is the community involvement in what you're doing, because you're doing such a wonderful thing. The volunteers I go with are top notch people, a retired New York City policeman, a woman who owns a dress shop, just plain folks like myself. Now, if you brought in that community involvement, don't you think that you'd get that community support for the legislative backing that you want?

It's been proven to happen before. In fact, none of you would be here today, I imagine, if it hadn't been someone like Ollie Randall or Ellen Winston or Jack Kosofski, who goosed the Congress into saying there's a need for an Administration on Aging. Who takes care of those older folks?

Those volunteers are critical, and now that you've been established, I sense you've let them go. The last speaker, Jim from Louisiana, fine, I understand what he said, but he said think of the cost involved to the volunteers. Think of the cost you're facing by not having the volunteers. Well, that's just one item.

I wrote here why keep it a secret what you're doing? What you're doing is keeping it a secret. It really seems as though the true effects of being warehoused in a nursing home and no one gives a damn about you, if that kind of feeling almost pervades what we're doing, your work and my work, that this business of being aged or being in a nursing home or a border home or adult home or a hospice, if you please, gee, that's way beyond the pail here, we've got nothing to do with it. We don't want to involve too much of anything in that. That isolation, I think, is what brings you to the problems you have here, and thank God for Senator Pryor who is trying to do something about it.

It wasn't too long ago the health system's agency programs died, you remember. Why did they die? Because they were right on the funnel of public funding, but they were voluntary-based, so they aborted that and became totally into the public domain, and, by God, they went out of existence.

I would suggest to you, and I've tried to do a little research on this, that there's a need for a national organization of volunteer ombudsmen. We don't need another national organization in the voluntary sector. My God, it's hard enough to raise money now, but you know I serve on the Allocations Committee for the Regional United Way in this area, and never does the subject come up about nursing homes or ombudsmen or volunteering or putting money into the kinds of things you need them for.

It never comes up. No one ever gives a hoot about it, and I think there is a need for a national organization, and instead of calling it the "last hurrah" I'd call it the "first hurrah," because that's really what we should be doing, caring for those who came before us.

The trouble with notes like this is you get ahead of yourself. I say, lastly, the cost involved, this infusion of new dollars, I think the new dollars are there. I'm not totally dumb. But the dollars would be there if you had that community support behind you, if you had the NCOA, if you had these voluntary organizations pushing. They'd have to turn attention to you, because the preponderance of the population is going to be going in your direction, so why not make use of it? And that's my pitch for volunteers, and sorry it was so long.

Ms. O'SHAUGHNESSY. Thank you. Could you just please say your name into the mike so that it can be recorded?

Mr. McMANNIS. The name is John McMannis. I live in Arlington, VA. What else would you like?

Ms. O'SHAUGHNESSY. I think that's it. That's fine. Thank you very much.

As other people approach the mike, would you please give your name and if you're representing an organization?

I believe that Susan has a comment on this.

Ms. McDONOUGH. Massachusetts does use a huge number of volunteers. In fact, we would not be able to do what we do without them. We have 226 volunteers of a staff of 300. Texas has 516. California has 700. Our ombudsmen in Massachusetts, no matter whether they are volunteers, stipended, or actually paid, do exactly the same work.

They are trained exactly the same way, they give us exactly the same level of service. They vary in terms of time commitments. A paid ombudsman might give us 40 hours a week, where the minimum number of hours we expect from a volunteer is 4 hours per week.

I take the role of volunteers very seriously. I have volunteers in the Massachusetts program that have been with me for 13 years, since the day our first local program opened. In fact, more than half of my staff of volunteers have been with me for more than 5 years, so I have had to make a commitment to them as well as they to me in the program.

We do train the volunteers. We provide for regular certification. We give 5 days of training. We require monthly in-service education. We recertify every local ombudsman on a biannual basis. We provide them with updated policies and procedures manuals. We do everything we can, but what we need are funds to do this.

You cannot do this by yourself and be the State ombudsman as well. You have to have somebody locally. Massachusetts is not a big State. Still, you need to have a person that is on staff in a local agency that can provide supervision for the ombudsman, who goes into the nursing home and identifies a problem that maybe she cannot resolve herself or she wants to have some back-up.

As I said earlier, support is critical, and if you do not have support locally or you feel like you are out there being a maverick and you are not sure if what you are doing is correct, you do not stay in the program very long. You also need travel money. Most of my ombudsmen are over 65 years old. The oldest ombudsman I have in the State is 93.

The ombudsmen in Massachusetts are not in a position to pay for travel, so you have to have the funds to pay them to travel. You do not have to pay them to do their work, but you have to pay them for their travel. You have to pay them for parking. In the urban areas, you have to pay for their bus passes, as I do in Boston. You also have to provide for other sorts of amenities.

You have to be able to recognize volunteers and tell them on a regular basis, you do a good job, or hold a lunch once a year to invite them in order to pat them all on the back and give them a pin, and that is not done without money. You have to have some funds.

I think it is a very telling comment, and this is my last point on this, that of the $24 million that exists for ombudsman funding, I believe Carol said half of that was Title III. That means about $12 million is Title III across the country. There is almost $2 million of that in Massachusetts. We are not unique in Massachusetts. We are in some ways, but, the difference is that we have had the support of the State unit on aging.

There have been major controversies. I would not be able to tell you that Massachusetts visits the board and care facilities weekly or we visit the nursing homes weekly and we provide information and do a lot of advocacy, unless I could support those volunteers.

So I disagree with you, sir, that we do not need more money, because Massachusetts is probably one of the best funded programs in the country, and I am facing trying to provide services, train my people, and make certain they do not have to pay to come to training, or that it does not cost them money to volunteer in my State. I guess I disagree with your point, but I do certainly echo your position, as well as the position of most ombudsmen in the country, that volunteers are absolutely critical to the success of this program in meeting the residents' needs. Thank you.

Ms. O'SHAUGHNESSY. That was a good interchange there. We have more questions.

STATEMENT OF ENID CASSNER, AARP

Ms. CASSNER. I'm Enid Cassner, with the American Association of Retired Persons, and my question is for Dr. Kautz.

Can you tell me how the States estimated the number of board and care beds? Did they only include licensed facilities, and, if so, are they only providing services to the licensed facilities? If they provide services to more, could the study perhaps even understate the degree of service to board and care homes?

Mr. KAUTZ. The States reported whatever they conbsidered to be their clientele in the board and care areas, and we didn't get into as sophisticated a definition of the question as you would like—and we would have liked. In our State, for instance, we included facilities which under State law we should serve—which are licensed and "subject to be licensed."

We couldn't, obviously, include those that are hiding out in various corners of woodwork around various cities, moving from place to place as the licensing people get close to finding them. I think the figure is understated. I think as more attention is focused on board and care homes, we'll find that the numbers of residents of those homes and the numbers of those facilities will be expanded very rapidly, not only because there will be more places opened, but because there will be more places found.

I would guess that our responsibility in terms of board and care beds is considerably understated in this report.

Ms. O'SHAUGHNESSY. We have a couple of other questions here.

STATEMENT OF VIRGINIA FRAZIER, COLORADO STATE OMBUDSMAN

Ms. **Frazier**. I'm Virginia Frazier, and I'm the State Ombudsman in Colorado. I'm also President of the National Association of State Long-Term Care Ombudsmen.

I'd like to ask Jim, given the per bed funding difference between your program and Susan's, what are some things that you would like to do if you were in Susan's shoes?

Mr. **Kautz**. I'd like to be able to talk like Susan. Every now and then I call her just to hear her say "car" and things like that. [Laughter.]

Everybody knows that Massachusetts has a problem with fiscal responsibility. But seriously, I know very, very well from listening to Susan and observing what they've done that they can pull off a whole lot more and they're a lot more involved in what I would classify as "systems work."

When you have, as I do, between one and two—depending on how you count—full time equivalents at the State office and money is spread out amongst 31 area agencies on aging for us to help and monitor, there's not a lot of time in our day to go to the legislature, to become well-known to the key legislators, to consider filing class actions, and to consider some of the more sophisticated approaches which deal in one sweeping blow with hundreds of residents.

We are more reactive to individual cases, and we cannot get into the more sophisticated systems impact types of cases.

You can't rate ombudsman programs and their excellence strictly on the basis of how often they get into a nursing home, by the way. That's important; there's a limit to how much you can do unless your people are out there knowing the residents and knowing the nurses and knowing the nurse assistants, but some of our programs have chosen to use their funds in other ways so that they can do systems advocacy.

So I hope we haven't left the impression that it's a bad program somewhere in some State that doesn't see every nursing home every week. We just think that weekly presence would be a standard that should be aimed for and reached and that it would cost something to do that, either in dollars or volunteers or both.

Susan's program does some things that we don't do, and the ones I've mentioned are those that I sense that they do and that we would like to do and can't, given our staffing and level of sophistication.

Ms. **O'Shaughnessy**. Do you have other questions here in the back? Maybe in order to save time, if other people have questions, we have time for about, I think, one or two questions after this, if you will just line up.

STATEMENT OF DAVID HARVEY, NATIONAL ASSOCIATION OF PROTECTION AND ADVOCACY SYSTEMS

Mr. **Harvey**. I'm David Harvey with the National Association of Protection and Advocacy Systems. I haven't heard much comment by people here about cooperative efforts at the State level between LTCOs and State P&A agencies, and, as most people know, P&As are authorized by separate legislation and do similar types of activities in terms of providing legal assistance to people with disabilities. Is there any comment on that?

I know that in the 1987 reauthorization of the Older Americans Act as well there was mention of facilitating efforts between LTCOs and P&As, and I just wanted to hear a comment on that.

Mr. HORNBOSTEL. I'll be glad to address that very quickly and just say that you'll notice somewhere buried in my written statement there's a reference to the fact that in Ohio our protection and advocacy network is actually set up with a separate ombudsman program that serves the mentally ill and mentally retarded persons in a way that traditionally the P&A organizations do not serve them, and that is in terms of investigating and handling individual complaints that may not lead to litigation.

We've worked very closely with our protection and advocacy agency in Ohio, which is the Ohio Legal Rights Service in terms of doing some cross training and so forth, and I will just say, though, that as I look at both programs nationally, I do sense that at some points we operate somewhat at cross purposes. The thrust of protection and advocacy agencies seems more toward serving those people who receive community-based services as opposed to institutionally based services. Some of our ombudsman folks have even been told, well, your function is not as important, because you're serving those people who are in institutions and are already receiving some protection.

We don't buy that, I think that our Ohio P&A agency doesn't buy that, and we hope that the national organization doesn't buy that line of reasoning, either.

Ms. O'SHAUGHNESSY. Thank you.

Next question?

STATEMENT OF JEAN O'LAWNEY, AMERICAN ASSOCIATION OF HOMES FOR THE AGING

Ms. O'LAWNEY. My name is Jean O'Lawney. I'm with the American Association of Homes for the Aging. I have two questions, and I know we're short on time, so if you could briefly touch upon these two areas. One is, how do you relate with the State survey and certification system, which inspects the quality of care? And the second question is, briefly describe how you relate to the facilities, the administrators, the clinicians, if at all, and if you find good care, exceptional care, in a facility, is there anything you do about that?

Ms. O'SHAUGHNESSY. Before Susan begins, I just want to say the Committee will be around to pick up your comments if you have any about the workshop format.

Ms. MCDONOUGH. I would love to address your first question. I have a very strong memorandum of understanding between the licensing and certification agency and my office regarding who will do what and when. Generally, we will attempt to resolve the complaints in the facility, and, as I said, we are very successful.

We have an excellent reputation, I believe, within the Massachusetts provider community for working with them to resolve the complaints, and therefore we are not in a position to have to refer a large number of the complaints to a regulatory agency for resolution. There complaints are resolved by the providers.

We do investigate all the reports of residents' rights violations for the Department of Public Health, as it is called in Massachusetts, and we are required by State law to report all instances of abuse in nursing homes to the licensing agency. We have found that, whenever possible, the ombudsman will attempt to investigate the situation, and if it is unresolvable, we will refer it to the licensing agency.

We provide some monitoring of the survey documents and the plans of correction. All the ombudsmen receive surveys with the plans of correction attached. If we find a facility that has been cited for serious violations and is not adhering to the plans of correction, my office is called, and I call the State certification agency, and they will go and do a review.

In terms of the second part of your question, I believe that I have a very good working relationship with the providers in Massachusetts. They know that we are fair, they understand what to expect from my programs, they know that if it is not resolved, we will take it to a regulatory agency.

We have a fairly candid exchange of views on occasion. I do not agree with them on some things, they not with me on others. We have a fundamental difference, I believe, about Medicaid discrimination in Massachusetts. When we do find providers that are doing a good job, we try to identify them. Right now, we're working to improve board and care facilities.

Massachusetts, I am sad to say, for a long time, with the exception of the Executive Office of Elder Affairs, I believe tried to pretend that licensed board and care facilities do not exist. No attention was paid to them, they did not receive the upgrades or salary pass-throughs that we got for nursing home staff. They are largely untrained.

Right now, I'm trying to organize my colleagues in State government to look at those facilities that are good and analyze them and try to replicate. I believe that to a certain extent the providers believe that I will advocate for improvements in the rates and so forth, as long as I believe that they are trying to improve quality of care for the residents. Therefore, we have stood on certain issues as allies and on others as opponents. I think that we have a good blend for a working relationship.

Ms. O'SHAUGHNESSY. I think we have time for one last question. We will have time, obviously, at lunch and afterwards to do some more discussion.

STATEMENT OF ELMA HOLDER, NATIONAL CITIZENS COALITION FOR NURSING HOME REFORM

Ms. HOLDER. I'm Elma Holder with the National Citizens Coalition for Nursing Home Reform, and I just want to say a couple of things, but mostly to indicate how important it is for the Senate Committee on Aging to look at this effort to strengthen ombudsman programs, particularly in view of the new nursing home reform law, which is to be implemented in October.

I believe that the ombudsmen and their services, whether they be paid or official or volunteer in any capacity, that program is going to be critical to the actual implementation of the reform law, so I think it's an appropriate time to look at strengthening the program, making sure that its advocacy role, which Dr. Arthur Fleming so ably laid out for us, continues and that it gets at every level the needed support financially.

I don't think it's wrong at all for us to—sometimes we get embarrassed about talking about more money or we get kind of reluctant to because of budget crunches here and there and everywhere, but this program needs a lot of money, as has been indicated and I think laid out so well by the panel this morning.

I know that our contacts with citizens throughout the country and residents, they know how valuable this program is, so we want to add our voice of support for your strengthening the program. Thanks.

Ms. O'SHAUGHNESSY. Thank you.

Anne, did you have a comment on the previous question?

Ms. KISOR. Yes, thank you. I've been sitting here quietly chafing in my chair a little bit and chomping at the bit, ready to make a comment on a few things I've heard. I think it's really good to have people here today from State programs that are running good, effective, efficient programs for residents. I think, unfortunately, most of the other States are muddling along somewhere in the middle. A lot of Jim's research sort of reflects that.

In Pennsylvania, we've had some problems in terms of getting uniform intent on the State level, and this does trickle down to our day-to-day business. I think that it's very important in particular to get a working relationship with the State certification agency, and, as Elma noted, this becomes amplified as the ombudsman now takes a greater role in the survey process.

It's very critical that the State offices at least learn to disagree, even get that far, and begin talking about some of these things, because the process is being piloted now, and we're being asked to go out and work with our local departments of health, and I think that without some further direction on the State level, the end point is that it ends up undermining the intent of the Act for the residents, and that's something that we don't want to have happen. Thank You.

Ms. O'SHAUGHNESSY. Thank you, Anne.

I think we've just about run out of time. We're a couple of minutes over. I'd like to give the panel a nice round of applause.

I think everyone did a super job, and we'd like to thank them very much. At this point, we're going to break for lunch. At the bottom of your agenda, you have directions as to where to get a sandwich. We ask that you come back promptly at 12 to hear Dr. Eli Cohen and begin our informal discussion. The Committee staff is going to be around to collect your comments on the workshop format, and thank you very much.

[Whereupon, at 11:30 a.m., the workshop recessed, to reconvene at 12 p.m. the same day.]

AFTERNOON SESSION

Ms. O'Shaughnessy. We're going to continue with our luncheon speaker and then have some more discussion with the audience participants a little later. We have as a special quest for this lunchtime break a noted colleague in gerontology, Dr. Eli Cohen. Dr. Cohen has a seven-page resume, so I have picked out a few things to say.

He's not only a gerontologist, he's an attorney, he has been a regulator, and, as he indicated to me before this session, he was also a defendant as a State official in the public sector. He is currently Vice President of the Community Services Institute in Philadelphia. He has served at the Pennsylvania School of Medicine; he was formerly Director of the Office of Family Services with the Pennsylvania Department of Public Welfare; and he was Director of the Public Interest Law Center Philadelphia.

He was for 6 years Editor-in-Chief of "The Gerontologist." He is the author of 60 articles, chapters, and books on gerontology and health care, and has a long list of achievements and awards. He was involved in the 1961, 1971, and 1981 White House Conferences on Aging. But the thing I like the most about his resume is that one of his former titles was "Humanist in Residence" of a public T.V. and radio station in Harrisburg. It's my privilege to introduce Dr. Cohen.

STATEMENT OF DR. ELI COHEN, VICE PRESIDENT, COMMUNITY SERVICES INSTITUTE OF PHILADELPHIA

Mr. Cohen. Thank you. This is a particular privilege for me, since I was here at the beginning when this Senate Special Committee on Aging was a subcommittee of the Committee on Labor and Public Welfare, and Sidney Specter was the distinguished director of the Subcommittee and went on to take on the staff directorship of the Special Committee. At that time, he asked me to help with the writing of the first report, and, if my memory serves correctly, I think I ghost-wrote the section on social services and the elderly.

Back in 1956, when I came to Pennsylvania as its first Commissioner on Aging, there were only four State executives in the field. It sounded a bit like a Jewish law firm. It was Kuplan, Kaplan, Kaiser and Cohen. We were in California, Minnesota, New York, and Pennsylvania.

What I want to say today is really more in the nature of some broad overview remarks regarding the long-term care ombudsman and the legal service programs authorized under the Older Americans Act, rather than a set of proposals that are incorporated in the reauthorization bill. Before I plunge in with some comments and criticisms, let me hasten to add that I am mindful of the splendid and long-time work of the National Senior Citizens Law Center, the National Council on Aging, Community Legal Services, and a host of others who have been fellow toilers in the vineyard.

But I would say at bottom, while some of my remarks are critical, I also believe that it's doubtful that changing the boundaries of the legislative mandates or authorizations would significantly affect the problems and issues that I believe deserve greater attention. I'm not unmindful about resource problems, cultural value problems, and systemic problems. However, I have seen other programs, which I'll mention, where advocates with minimal resources, where programs that were crying out for systemic reform, were changed and where interventions worked.

It may seem strange in this setting which addresses legislative change for me to take as my first point something that does not involve legislative change but rather looks at the interface between moral obligation and legal obligation.

The vindication of the civil rights of members of society who have traditionally been relegated to lower status has always been preceded by advocacy by individuals who have asserted rights acquired under natural law, endowment "by their creator with certain inalienable rights," ethical principles, or the weight of world or other history. This is true of the history of blacks, Native Americans, women, people with disabilities, the mentally retarded, the mentally ill, and, to some extent, the elderly.

In the beginning, so to speak, there was the word; then came the legislation and the opinions of the courts. Let me give you a simple analogy or example. There was a time when people of color were regarded as property, absolute property. And there were those who, in the very earliest days of the colonies and later the Republic, said, "yes, it's true, these folks are property, but even as property, they have certain entitlements which may have to do with housing or clothing or feeding or care and so on." They said, "Regarding human beings like a horse, or a table simply isn't right". They weren't quite ready to grant full status, or full recognition to slaves as human beings, but they recognized something that was different.

This notion started out as the moral obligation, and that was subsequently incorporated into State law, honored in the breach, to be sure, but it was incorporated into State law long before the 13th and 14th amendments and long before the Civil War. Then, we experienced our great national convulsion—the Civil War. Some of the causes of that war were economic; some concerned turf; and still others, the nature of sovereignty. But there was a pervasive theme: revulsion over the moral injustice. Then came the law.

Following the war—and for too long—there was the notion that "separate but equal" was good law. But there were those I would call the ethicists, those who sensed a different moral obligation and who pressed in every way they could until *Brown* v. *Board of Education* was decided and "separate but equal" as a legal doctrine was struck down.

There are limits in our system. I doubt that the legal obligation under our system will intrude to the point of requiring private nondiscrimination. We may keep extending the boundaries of public, but there will be a limit that we will reach, and that will be left to the arena of moral obligation.

But there are public responsibilities to change the perception of what moral obligation is, and, happily, I think we have begun to undertake some of that, whether it's in schools' textbooks, in the behavior of leadership or the public utterances of leaders and the influence makers. But at some point the law will stop. And this is where the interface between legal and moral obligation occurs.

Moral obligation, I would suggest, when generally accepted produces wider, deeper, and perhaps more effective behavioral chance than naked law enforcement. Aseptic technique in the operating room is more a function of the perceived obligation to maintain it than the fear of malpractice or the white glove inspection of the health department regulator.

I would suggest in this connection that there is a limit to how far health regulation or the regulatory processes involving nursing homes are going to get us to the point of having nursing home care meet the standard that we want for our boss's mother. We have to strip out the emotional baggage that some people may bring to this.

I was Pennsylvania's cop for a dozen years, and I felt we had a fair statute. I had good support from the governor. I had an honest staff, a dedicated staff. Beginning in 1956, after 12 years, I think I managed to get the State standard of operation up to about 1950, and I wondered why I had failed.

God knows we worked hard. We were tough. We probably ran roughshod over the civil rights of nursing home owners in our effort to straighten things out. We were very, very tough cops, but it really didn't work, and I went back to law school to see if they could tell me why. I learned some things there, not the least of which was that there are limits to how far you're going to get with raw naked regulation. I honestly believe that. That's not to say that regulation isn't essential; it is, but it is not the whole ball game.

Americans look to "Mother Congress" to fix things that don't work. Whatever the problem, let's find a legislative solution.

Many years ago, this committee published a set of documents, entitled, I believe Nursing Home Care: The Failure of Public Policy. There were some 14 volumes to the set. Senator Moss rushed in with 37 bills—37 bills—on nursing home regulation and improvements in nursing homes. None were enacted. If they had been passed, I doubt that much would be different today.

We should free ourselves from this rush to legislation. In Pennsylvania right now, we've got 150 to 175 people inspecting 650 nursing homes. And yet, we do not find a major effort by either the ombudsman or legal services programs to change the system so that the people who really don't want to be in nursing homes and who, incidentally, may be making foolish decisions on being out, can have those foolish decisions vindicated.

The civil rights of people in nursing homes are being overridden every single day of the week. It's tough to get at that.

I believe that focusing on those civil rights is a function of our efforts to enhance the understanding of moral obligations to older people with disabilities with the intent of better shaping the effectiveness and parameters of the legal obligations.

Focusing almost entirely on legal formulations has limited our vision. The result has been that we have embraced notions like the right to the least restrictive alternative, really a very low goal when you think about it. What's the big goal? To stay out of a nursing home? There is a world of difference between merely and vindicating the right to flourish.

The women's movement, the independent living movement, and the mental retardation movement have vigorously pursued the right to flourish! The Aging Movement has not yet understood it. Those three particular movements have been very effective, in my view, because of the intellectual joinder of the sense of the moral and legal obligations.

Take the burning issue of Alzheimer's disease and the treatment of the Alzheimer's disease patient. Alzheimer's disease patients can flourish. They flourish differently from you and me. They flourish in little bites of time. They live an existential life. They don't remember what happened yesterday. That puts a different demand on me as a care giver. I'm not going to get the same kind of feedback. I'm going to get it in terms of what happens now. Can this patient flourish for this little bite of time? It's a different point of view.

I look back at what Judge Bazalon had in mind when he wrote his opinion in *Lake* v. *Cameron*. I think he understood the right to flourish even though he articulated it in terms of "lease restrictive alternative."

Let me talk a little bit about vision and leadership. A number of factors have been cited as barriers to more effective long-term care ombudsman and legal services programs. They include, among other things, access, jurisdiction, the problems of standing and relationships, real or imagined conflicts of interest; the independence of the ombudsman and legal services from their respective funding sources at the State or sub-State levels, capacity, that is insufficient resources, legal liability, inadequate availability of staff, the need for training; and an unsophisticated public resulting in inadequate protests over injustice and a demand for system reform.

But these barriers, while real enough, are made even more powerful by the remarkable inattention to system reform, whether we address the long-term care system, the social service system, the mental health system, or other human services systems. I understand the dollars issue. I know how much it costs to undertake law reform and to pursue the case into the appellate courts. But now, speaking to my legal services colleagues, I would say we ought to be thinking about doing for our clients what General Motors' lawyers do for their clients. That's everything. You do everything.

You do the public relations, you do the legislative analysis, you help with the press release, if necessary you go out and you organize the dealers or you set up the plan for organizing the dealers or former customers, or whatever it takes to deal with the issue. We've got to begin thinking about those kinds of issues. I'm heartened by Roland Hornbostel's recognition of the importance of system reform needs.

But system reform necessarily would address the beloved categorical approach which sees the mental health system excluding the elderly with organic brain damage—despite the fact that they suffer terrible psychic distress and can benefit from the techniques and tools of the mental health system—or which sees the health care system effectively excluding the chronically disabled—as opposed to the chronically diseased—or the social service system which has effectively excluded the chronically mentally ill or disabled, and so on.

What category do the elderly homeless fit into, they who are so unlovely?

I recall Carol Estes' book, "The Aging Establishment" and her concern about how we focus and what we're focused on. Inattention to system reform, I have to say, suggests some limited vision on the part of those who have been charged with leadership. It takes form in many ways.

What is the vision of legal services, and what is the vision of the ombudsman programs? What happens if they are 100 percent successful in terms of the vision they currently hold? Do the systems change? Do we solve disputes and win cases one at a time, one by one? Do we go in and try to visit 1,200,000 people in nursing homes? What's the vision of the State units and the AAA's? Is it to garner resources for categorical approaches, or is it to render this State or this PSA a wonderful, hospitable jurisdiction to which all elderly can come and flourish and grow and become?

In Pennsylvania, a resource-rich State, in my State we've got the lottery. We're putting big bucks into aging. I wish I would just hear somebody once say what we really want is for Pennsylvania to be a wonderful place for old people to live, or a place in which you can grow old and know that you're going to be able to get good medical care, that you're going to get a whole set of social services, or there will be places to go and transportation to take you there, an things where you will have a full life in which you can flourish, where you can be a good grandparent, where you can be a good neighbor, where you can work if you want, if that pleases you, or be a volunteer, or whatever.

It's time we began to examine some other models and the advocacy strategies they've pursued. This is not to say that they have been 100 percent successful; rather it's, to say that they're different and project a different point of view. A careful look at the women's movement, the independent living movement, mental retardation, may suggest new strategies and improvements on existing strategies.

Some elements of system reform are in place, many are not. What do we need?

First a vision of what goes into system reform, understanding the systems, their limitations, the failures of underlying assumptions, the distribution of power, the identification of villains and victims, the courage to take on the barriers to system reform, including the funding agencies from whom we get our money. That may require independence.

Legal services in Pennsylvania gets its money from an agency and proceeds to sue that agency. That doesn't trouble it too much.

It means having the courage to utilize all of the tools available and essential to system reform: the empowerment of consumers and finding resources to finance that power; the constructive use of tough publicity; the development of innovative methods.

I've always loved and I've never been able to figure out the analogy to what the FDA does. When they catch a drug company with a labeling problem, they have a little device that they call the "Dear Doctor Letter." They require the drug company to send a letter to every doctor in the country saying, "hey, we made a mistake, and we want to call this to your attention." Drug companies hate the "Dear Doctor Letters". You can understand why. It's very expensive and they eat a lot of crow publicly. But it works. It's a good device.

The use of the class action lawsuit continues to be useful. I note with interest the *Hoffman* suit in Chicago, but I would say what we should be focusing less on procedure and the process, and more on the broader goals. We should focus attention on conduct of the underlying legal and substantive research essential to advocacy system reform and where appropriate on the use of State law. And we must engage in major efforts in advancing the sense of moral obligations.

We should take Title I of the Older Americans Act more seriously than we do. Do the strategies we're employing get us to the goals so well-articulated in that purpose section, or have we been caught up in the triumph of technique over purpose?

In sum, I suggest that the consideration of the reauthorization of the Older Americans Act should be viewed as an opportunity to try some different perspectives. I suggest that we consider the power of moral obligation and the role of Government in enhancing the sense of moral obligation. I suggest placing system reform on at least the same level as our one by one approach to complaint resolution. Finally, I suggest that we revisit Title I every time we look at any provision of the Act. Thank you very much.

[The prepared statement of Dr. Eli Cohen follows:]

SUMMARY OF REMARKS
ELIAS S. COHEN J.D.
AT THE
CONGRESSIONAL SEMINAR ON THE REAUTHORIZATION OF THE OLDER AMERICANS ACT
June 28, 1990
Washington, D.C.

These remarks are more in the nature of an overview of the Long Term Care Ombudsman and Legal Services programs authorized under the Older Americans Act than a set of proposals to be incorporated in the Reauthorization Bill. Indeed, while some of these remarks are critical, it is doubtful that changing the boundaries of the legislative mandates or authorizations would significantly affect the problems and issues I believe deserve greater attention.

The Interface Between Moral Obligation and Legal Obligation

The vindication of the civil rights of members of society who have traditionally been relegated to lower status has always been preceded by advocacy of individuals who have asserted "rights" acquired under natural law, endowment by "their Creator with certain inalienable rights . . .", ethical principles, or the weight of world (or other) history. This has been true of the history of Blacks, Native Americans, Women, People with Disabilities, the Mentally Retarded, the Mentally Ill, and to some extent, the Elderly. In the beginning, so to speak, there was The Word---**then** came the legislation, and the opinions of the courts.

It is also the case, that the vindication of rights via legislative or judge-made law has limits beyond which it is difficult to proceed. Moral obligation when generally accepted produces wider, deeper, and perhaps more effective behavioral change than naked law enforcement. Aseptic technique in the operating room is more a function of the perceived obligation to maintain it than the fear of malpractice or the \white glove inspection of the health department regulator.

There is a powerful relationship between the world of moral obligations and the world of legal obligation. Indeed, it is and can be synergistic.

The comment is relevant to this Seminar. The Congress has labored mightily on the issue of Nursing Home Reform. I recall Senator Moss' introduction of 37 bills to solve nursing home problems legislatively many years ago. The Long Term Care Ombudsman provisions and legal services programs similarly address the issues in our very American search for solutions through the rush to Congress to solve the problem.

My first point then is that the attention of both programs should increasingly be directed at efforts to enhance the understanding of moral obligations to older people with disabilities with the intent of better shaping the effectiveness and parameters of the legal obligations. Focussing on legal formulations has limited our vision so that we have embraced notions like the right to the least restrictive alternative (a very low goal) to the to the exclusion of or blindness to notions like the right to flourish (a point of view very much adopted by the Women's Movement, the Independent Living Movement, and the Mental Retardation Movement). Those three movements have been particularly effective because of the intellectual joinder of the sense of the moral and legal obligations.

Vision and Leadership

Many factors have been cited as barriers to more -effective long term care ombudsman and legal services programs. They include, inter alia, the issues of access, jurisdiction (problems of standing, relationships), real or imagined conflicts of interest; (the independence of the ombudsman and legal services from their respective funding sources at the state or sub-state levels, capacity, i.e. Insufficient resources, legal liability, inadequate availability of staff, need for training, an unsophisticated public resulting in inadequate protest over injustice and a demand for system reform.

However, these barriers while real enough, are made even more powerful by the remarkable inattention to system reform, whether we address the long term care system, the social service system, the mental health system, or other human services system.

System reform would address necessarily the beloved categorical approaches which see the mental health system excluding the elderly with organic brain damage, or which see the health care system effectively excluding the chronically disabled (as opposed to the chronically diseased), or the social service system which has effectively excluded the chronically mentally ill or disabled, and so on. What category do the elderly homeless, so unlovely, fit into?

Inattention to system reform suggests limited vision on the part of those who have been charged with leadership.

Limited vision takes form in many splendored ways. What is the vision of legal services and the ombudsman programs? What happens if they are one hundred percent successful? Do the systems change? Or do we solve disputes and win cases one at a time, one by one.

What is the vision of State Units and AAAs? Is it to garner resources for categorical approaches or is it to render this state or that PSA a wonderful hospitable jurisdiction in which all elderly can flourish, grow, and become?

Looking at Other Models

It is time we began to examine some other models and the advocacy strategies they have pursued. This is not to say that they have been successful---rather it is to say that they are different and project a different point of view. A careful look at the Women's movement, Independent Living and Mental Retardation may suggest new strategies and improvements on existing strategies. We should take Title I of the Older Americans Act more seriously than we do. Do the strategies we are employing getting us to the goals so well articulated in that purpose section, or have we been caught up in a triumph of technique over purpose?

In sum, I suggest that the consideration of the Reauthorization of the Older Americans Act should be viewed as an opportunity to try some different perspectives, to consider the power of moral obligation and the role of government in enhancing the sense of moral obligation, and an opportunity to revisit Title I every time we look at any provision of the Act.

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Ms. O'SHAUGHNESSY. I think we can all understand why Dr. Cohen was in a position entitled Humanist in Residence. I think we sometimes need to focus on the broader philosophical basis for what we do and what we expect to achieve.

The second half of our workshop is going to focus on legal services. Legal services differ from the other service programs that are authorized and funded under the Older Americans Act, which employ primarily social workers to assist elderly in gaining access to the system that we want to see.

I hate to talk about a legal requirement or regulatory requirement after hearing Dr. Cohen speak, but just to give you some perspective on legal services, it is one of the three priority services under the Act. The Act requires that each area agency spend an adequate proportion of funds on legal services; however, adequate proportion is not specified by the law. The law instead allows State agencies to determine what is the minimum proportion to be spent on legal services. This, obviously, has been an issue in the program for a number of years. States can also grant waivers if the area agency can show or demonstrate that adequate legal services are being provided in the planning and service area.

To the extent that there is a need for data on what is a "adequate proportion" and what States have decided is the minimum percentage to be spent on legal services, the Senate Special Committee on Aging is in the process of doing a survey on legal services and in May sent a questionnaire to all State agency directors. Surveys are still coming in to the Committee, but the response, as I understand, has been fairly good. The Committee is in the process of looking at those responses and will be doing some follow-up with the State agencies to determine what additional information is needed. In each of your packets is a summary of the preliminary findings of the Committee's survey. The Committee wishes to stress this is premature information and that staff still needs to firm up some of the data.

At this time, the Committee intends to publish the findings of the survey as soon as this is completed. However, there are three preliminary findings which we may find useful for today's discussion. First, it appears that relatively few law schools and non-attorney advocacy programs receive contracts for Title III. Maybe some of you have some comments about this later.

Second, it appears that States employ a wide variety of measures for determining the amount and type of legal services that contractors provide. Third, for the States that were able to provide information about the types of cases that are handled by legal services providers, the most common types of cases are consumer protection, durable power of attorney and living wills, estate and probate matters, and housing.

So you may want to take a look at these preliminary survey findings at your leisure. The Committee wanted me to point out that some of the pages in the handout are out of order, so you may want to put those in order.

Our first speaker this afternoon on legal services is Ann Fisher. Ann is a Senior Attorney with the Legal Assistance Foundation of Chicago with the Disability Law Project. Prior to her position there, she was a Law Clerk in the U.S. Court of Appeals for the 7th

Circuit and a Law Clerk in the District Court for Eastern Michigan.

Ann is going to talk to us about a very interesting case that she handled regarding legal services in the ombudsman program, so it's a very good bridge for this afternoon's session.

STATEMENT OF ANN FISHER, STAFF ATTORNEY, LEGAL ASSISTANCE FOUNDATION OF CHICAGO

Ms. FISHER. Thanks. I, too, after hearing Dr. Cohen think we're moving from the sublime to the ordinary. I'm going to tell you about a fairly ordinary case we did that nonetheless was unique in the country and really made a difference for Chicago nursing home residents.

As was mentioned, I'm a Staff Attorney with the Legal Assistance Foundation of Chicago. The Legal Assistance Foundation, LAFC, is the legal services provider for the city of Chicago. We are not the Title III senior legal services provider. There is a smaller organization, the Legal Aid Bureau of Chicago, that has that grant, so we didn't have any of those conflict issues that I think would trouble many people in this kind of litigation.

I'm going to talk to you briefly about our attempt to provide legal services to nursing home residents without an ombudsman program to back us up and the lawsuit we then filed and recently settled to ensure that nursing home residents in the city of Chicago did have an ombudsman program. Obviously, we concluded you cannot provide legal services to nursing home residents without an ombudsman program.

I think it's fair to say that until 1987 neither LAFC nor the Legal Aid Bureau, the Title III legal services provider, was providing any legal services to nursing home residents in the city of Chicago. We're a big program, we operate out of neighborhood offices. Like any legal services program we're absolutely swamped by the phones ringing off the hook and the people coming in through the door. We have more work than we can possibly handle. We're always setting priorities and refining them and excluding new categories of cases.

Nursing home residents aren't going to make it in through our doors. As I discuss more in the materials and as some other people have discussed today, as a practical matter, nursing home residents often can't even pick up a phone and call a legal services lawyer.

The Legal Aid Bureau in Chicago, at the request of the Chicago Department on Aging, which is our area agency on aging, was providing legal services in the senior centers and providing just those kind of services we just heard about. They were doing probate matters and some real estate matters and some consumer matters, but not providing services to nursing home residents. The city department on aging certainly was not expecting them to provide those services.

We saw, as did organizations throughout the country, that there was an unmet need for legal services for nursing home residents. We received a grant from the Retirement Research Foundation to begin a legal outreach program to nursing home residents. We went to nursing homes, we spoke at Resident Council meetings, and we handed out residents' rights information. Then we set up in the back of the activity room and invited residents to talk to us. We told residents if there's somebody you think we should see, point them out, and we'll see what we can do.

The residents were delighted to see us. They brought us the problems with missing property and questions about what had happened to their trust fund money and whether their spend-down amount for the Medicaid eligibility was right. They talked to us about the problems they were having with their families and the problems they were having with staff. We have people in here who know just what those kinds of problems are.

We did what we could. We have two lawyers who were both assigned part-time to the outreach project. For we had a paralegal. On and off, we had law students. We all did the usual bit. I distinctly remember our paralegal crawling under a resident's bed looking for dentures—that's what you sometimes have to do and we found the dentures.

We pored over trust fund records, we talked to administrators, we talked to directors of nursing, we talked to families, and we went to public aid hearings. We've got a very elaborate discharge hearing in our Public Health Department for residents being discharged, so we represented nursing home residents at discharge hearings.

I think we did a fairly competent job at what we were doing, but the problem was that our efforts were both too much and too little. Our efforts were too much, because there was simply no reason that lawyers, even at legal services salaries, needed to be doing that kind of work.

In some ways, I would rather be crawling under a bed looking for dentures than doing some of the things that I'm expected to do when I'm sitting at my desk wearing a lawyer hat, but the truth is that you don't need to have a law degree to go looking for dentures or even to look at trust fund records. It was simply not an effective use of lawyer time to be out resolving these kinds of problems for nursing home residents.

Our efforts were also too little, because we couldn't begin to meet the demand for our services. Roland talked a little about this this morning, and I think it's universally true that nursing home residents need someone out at the facility, and they need someone out there often, and they need someone whose job it is to cut through the red tape and resolve problems for them.

So there we were trying frantically to get to—I don't remember what we had promised—30 nursing homes in the first year out of 100 in Chicago, and the residents were saying when will you be back? Will you be back next month? When will we see you again?

At that point, we started calling up other legal services programs; perhaps we should have done this long before we asked how they provide legal services to nursing home residents, and they said, why, the ombudsman program, of course, So we pulled out Title III, and, sure enough, there was something that suggested that Chicago nursing home residents were entitled to an ombudsman program.

We started investigating and discovered that indeed there was somebody in the city of Chicago in the local area agency who was designated as the nursing home ombudsman. The problem was it was the same person who was designated as head of Protective Services. She had a small staff and a small budget. Elder abuse was a priority of the city department and she was a well-trained, conscientious social worker. When people are starving and being beaten and being kicked out of their homes all over the city, it's hard to say I'm going to stop doing this and start doing regular visits to nursing homes. She and her staff were swamped with elder abuse cases

The State Department on Aging had actually issued some fairly decent standards but wasn't doing any training and wasn't enforcing the standards at all, totally apart from the Illinois political questions of when Springfield can and can't say something to the City of Chicago.

So at the service level, people were saying we're swamped, we can't do it. At the policy level, they were saying, frankly, it's not a priority. We have other things to do with our money, and this is not where we choose to put our money and invest our time.

This is where lawyers come in. We filed a lawsuit, a classic, garden variety class action lawsuit on behalf of all of the residents of Chicago nursing homes age 60 and above, seeking to enforce the ombudsman provisions of the Older Americans Act.

We filed the lawsuit in May 1988. In March of this year, March 1990, the court finally approved a settlement of the lawsuit. The settlement runs 18 pages and a lot of it is standard lawyer language dealing with topics such as class notice and how we're going to monitor the settlement, but a lot of it is substantive.

Your written materials detail the settlement pretty thoroughly, but I want to just discuss a couple of the highlights. We've talked a lot about outreach here today. In Chicago, before we filed the lawsuit, the average nursing home had any contact at all with the ombudsman program once every 2 years. The settlement calls for quarterly visits. I have to tell you that before this morning I thought we were wonderful to have quarterly visits in Chicago, until I came here and heard that Massachusetts has weekly visits. I guess this points out that although you can get some things with litigation you can't get a perfect, wonderful program with litigation, and you never will.

The settlement requires quarterly visits in Chicago, plus monthly visits to facilities subject to licensure revocation or decertification or found to have serious violations by our public health department. The settlement sets minimum staffing levels of one full time employee per 4,500 residents. In Chicago that meant two new full time employees in the Chicago ombudsman program, so that was enough to make a real difference.

At the State level, there are some good training provisions, and, in fact, the State has just completed a very good training program, so we're delighted about that, Somebody else also mentioned the importance of segregating out ombudsman funds, and, apart from the lawsuit, Illinois did decide to do that about a year and a half ago, and I think that's made a difference, too.

In terms of this particular panel this afternoon, we did have a few provisions that directly related to linkage between the ombudsman and legal services. We had a provision that the city had to comply with the State requirement on minimum spending, which is still abysmally low.

We also had a provision that the city had to explicitly contract with the legal services provider to provide back-up to the ombudsman program. It has to be in the RFP that goes out for legal services that the legal services provider will do back-up for the ombudsman.

Then, sort of at the last minute when we realized this was really important, we added to the stipulation that the ombudsman staff, and by that I mean the direct service staff, will meet monthly with the legal services staff. It's too early to tell yet whether this is going to make a difference, but we expect that at least we're going to start getting some information going back and forth.

We also got ombudsman legislation in Illinois. It doesn't begin to compare with what Roland was able to get in Ohio, but it meets the bare minimums. I don't think we would have gotten it but for the 1987 amendments, and perhaps the lawsuit also was a factor.

As a lawyer, it's sometimes easy to say that the goal of a lawsuit is the closed file or the court approval of the settlement. We try hard to remember that the goal of litigation is not the court approval of the settlement. The goal of this litigation was ombudsman services for Chicago nursing home residents.

I'm convinced that we've made a real difference there, too. Before I came here today, I received the reports for the Chicago ombudsman for the first quarter of 1990. The first quarter of any year is not a good time to be running around Chicago. January, February, March are not pleasant months in the city of Chicago. In that quarter, though, the Chicago staff made 104 visits to nursing homes, had almost 20,000 contacts with residents, and responded to 300 complaints.

From what was essentially zero several years before, I'm convinced that that's real progress for those residents. No, we didn't turn Illinois into a model program, but I think we were able to show that the ombudsman requirements are clear enough that they can be enforced and that enforcement can make a difference.

I don't get the credit for the changes in the Chicago program. That credit goes to these people who were out there in that bad weather visiting those homes and talking to those residents and investigating those complaints. But we do feel like we made it possible for these people to get those jobs and go to these homes. The rest is up to them, and I'm delighted to have them on the job.

[The prepared statement of Ann Fisher follows:]

TESTIMONY OF ANN HILTON FISHER REGARDING ENFORCING THE NURSING HOME OMBUDSMAN REQUIREMENTS OF THE OLDER AMERICANS ACT IN THE CITY OF CHICAGO

JUNE 28, 1990

My name is Ann Fisher. I am a senior attorney with the Disability Law Project of the Legal Assistance Foundation of Chicago (LAFC). LAFC is the Legal Services Corporation grantee, but not the Title III-B legal services grantee, for Chicago. I am here to discuss our attempt to provide legal services to nursing home residents in the absence of an effective nursing home ombudsman program and the litigation we eventually undertook to enforce the ombudsman requirements of the Older Americans Act on behalf of Chicago nursing home residents.

A little over three years ago LAFC tried invent an ombudsman program for nursing home residents, although we didn't know to call it that. Like every legal services program in the country we cannot begin to meet the demand for our services. Nonetheless, we have always recognized that we also have an obligation to provide legal services to eligible clients who are unable to contact us or come into our neighborhood offices. Nursing home residents are one of those under-served populations.

Very few nursing home residents are able to make their way to one of our neighborhood offices. Although we are always available by telephone, we discovered unanticipated barriers there as well. Nursing home residents limited to a $30 per month personal needs allowance cannot afford to have phones in their rooms. Most have also learned that their money is safest if it is kept by the facility in a resident trust fund instead of on their person. As a result, many do not even have the quarter for a call from a pay phone.

The pay phones that are available for resident use are typically located along busy corridors. For residents restricted to their beds, the phones are as inaccessible as our offices. Many other nursing home residents have hearing impairments which make it difficult to use any phone, especially one located in a noisy corridor. Finally, nursing home residents are understandably reluctant to discuss their legal problems, especially problems relating to their facility, standing in a corridor across from the nursing station.

Accordingly, in 1987 LAFC sought and received a grant from the Retirement Research Foundation to undertake a legal outreach program to nursing home residents in the City of Chicago. We began going out to nursing homes. We spoke at resident council meetings, passed out our cards and a residents' rights pamphlet, and set up shop in a corner of the activity room, inviting residents who had questions to speak to us individually. The residents were delighted to see us. They brought us the problems nursing home residents have everywhere: missing clothing and personal property, uncertainties about financial obligations, questions about medical treatment, complaints about staff or other residents. They brought us to meet with roommates and friends who could not come to resident council meetings.

We did what we could. We crawled under beds looking for missing dentures, we talked to administrators, we pored over trust fund records, we helped residents file complaints with the Department of Public Health, we represented residents in medicaid appeals and at discharge hearings.

We quickly realized our efforts were both too much and not enough. They were too much because so many of the residents' problems didn't require legal intervention--they just required some advocacy. They were not enough because we simply did not have the staff to get to Chicago's approximately 100 nursing homes with any regularity. The residents were telling us the same thing--they kept saying that someone should come out to them and do this more often. One 75 year old Swedish woman even patiently explained to me that what nursing home residents really needed was an "ombudsman".

At that point we began calling up other legal services programs to ask how they provided legal services to nursing home residents. We quickly learned that most programs rely on their local nursing home ombudsman to do the outreach and much of the advocacy, referring to the legal services programs only the problems that required legal intervention. That sounded like a great solution. We didn't have to re-invent the wheel after all. The only question was why Chicago didn't seem to have an ombudsman program.

In Illinois, the Department on Aging (IDOA) has delegated the responsibility for establishing and maintaining a nursing home ombudsman program to the Area Agencies on Aging. In Chicago this meant the City of Chicago Department on Aging and

Disability. We quickly discovered that Chicago had an ombudsman program in name only. The Chicago program, which was one of the many responsibilities of an over-worked and under-staffed protective services unit, did no outreach and little complaint investigation. It had no volunteers. Virtually no one knew it existed. The average nursing home in Chicago had contact with the ombudsman program once every two years. The Chicago Bureau of Health Regulations had issued a Consumer Guide to Chicago Nursing Homes which made no reference to the ombudsman program. A letter I sent to the Chicago ombudsman, at the correct address, was returned "addressee unknown."

At a state-wide level, some individual programs were excellent, many were mediocre, and some were as bad as Chicago, but no one knew the difference. None of the sub-state programs had been subject to a compliance review. There were no state-wide training programs.

In May 1988, on behalf of three of the many nursing home residents who had sought our assistance, we filed a class action complaint, Hoffman v. Otwell (No.88 C 4163), in federal district court in Chicago. The complaint sought to enforce the nursing home ombudsman requirements of the Older Americans Act. When the Older Americans Act was amended we waited until the completion of the legislative session in Springfield to see if the necessary changes in state law would occur and when they did not we amended the complaint.

To their credit, both the state and the city defendants entered into settlement negotiations soon after the suit was filed. In March of this year the district court gave final approval to a settlement of the suit. Among other provisions, the settlement agreement:

> 1. Establishes minimum staffing levels for the Chicago ombudsman program of one full-time staff person per 4500 nursing home residents;
>
> 2. Requires Chicago ombudsman staff to visit every nursing home in the city at least once per quarter for the first year of the agreement;
>
> 3. Requires monthly visits to Chicago facilities that have been cited by the Department of Public Health for serious health or safety violations or are subject to decertification proceedings by the Department of Public Aid;
>
> 4. Requires qualified ombudsmen to investigate and resolve complaints;
>
> 5. Requires increased efforts to use volunteers in the Chicago ombudsman program;

6. Requires monthly meetings between the Chicago ombudsman staff and the Title III-B legal services staff;

7. Requires the establishment and enforcement of state-wide outreach standards, complaint investigation procedures, and minimum staffing levels.

8. Requires efforts to assure the rapid and effective flow of information and assistance between the ombudsman and other agencies of state and local government.

9. Requires state-wide training of ombudsman staff in accordance with the requirements of the Older Americans Act.

The Illinois legislature also eventually responded to the mandate of the 1987 amendments. In July 1989 Governor Thompson signed amendments to the Illinois Act on the Aging which for the first time gave a statutory basis to the Illinois program. The new Act guarantees ombudsmen access to facilities, residents, and records; clearly establishes the duty of the ombudsman to investigate and resolve complaints; provides immunity for ombudsmen and volunteers working with the ombudsman program; provides legal representation for ombudsman staff against whom suit is brought; and makes it a business offense to interfere with ombudsman staff or to retaliate against residents or staff who initiate or participate in an investigation.

Our goal, however, was not just to be able to present a signed settlement agreement to the court or to get a piece of legislation passed in Springfield. Our goal was a good ombudsman program for Chicago nursing home residents. We believe the Hoffman settlement has gone a long way toward achieving that goal.

Chicago has hired two new full-time employees for the ombudsman program. They are hard-working, energetic, and committed to the rights of nursing home residents. The program has begun actively recruiting volunteers and has expanded its creative use of Title V Senior Community Service Workers as nursing home visitors. The increased outreach has resulted in a high demand for ombudsman services. In the first quarter of 1990, in the dead of a Chicago winter, ombudsman representatives made 104 visits to Chicago nursing homes, had almost 20,000 resident contacts, and responded to over 300 complaints.

The improvement is also significant at the state level. IDOA has hired an additional full-time state ombudsman and completely revised the method for distributing ombudsman funds to local agencies. It has begun an excellent training program. The state now monitors ombudsman programs throughout Illinois and is an active participant in the national ombudsman network.

Obviously none of this could have happened but for the explicit mandate of the Older Americans Act. The settlement and the legislation both directly reflect the language of the Act. Where the language of the Act is direct and precise--for example in the obligation to investigate complaints--the settlement and the statute are strong. In the rarer instances where the statutory requirements are less precise--for example in the requirement that the ombudsman "have the ability to pursue administrative, legal, and other remedies on behalf of residents"--the situation in Illinois is equally unsettled.

Let me give you an example of how carefully everyone in Illinois was looking at the language of the Older Americans Act. One of the changes of the 1987 amendments was in the provision requiring access to residents' records. Before the 1987 amendments, ombudsman staff were required to have access to "patients' records." The 1987 amendments added another section which instead referred to "medical and social records." As a result, we found ourselves in a long and hard battle in Springfield over whether the "medical and social" language precluded ombudsman from access to residents' financial records. The battle was long and hard even though it was clear that it would be impossible to investigate a large percentage of complaints filed against either facilities or public agencies without access to those records. We finally prevailed, but only because we were able to incorporate the access provisions of the Illinois Nursing Home Care Act into the statute. On the other hand, I can assure you that but for the amendment's language providing "appropriate access" to the records of residents who are unable to consent but have no guardian, ombudsman staff in Illinois would be effectively cut off from any advocacy on behalf of thousands of Illinois' neediest nursing home residents--those who cannot advocate for themselves and have no one else to advocate on their behalf.

The work this committee has done on behalf of nursing home residents is important. The Committee had a clear view of what a nursing home ombudsman program should look like and expressed that view in clear language. As a result, we were able to enforce the provisions of the Older Americans Act to provide an effective nursing home ombudsman program for the City of Chicago. On behalf on Doris Hoffman, Boni Taylor, and the thousands of other Chicago nursing home residents, we thank you.

Ms. O'SHAUGHNESSY. Thank you, Ann. That's certainly a good example of where a group of people have made a difference.

Our next speaker is David Manley, who is Director of Litigation for the Legal Services of Arkansas. David established a program of pro bono legal representation for seniors and has served as legal counsel for the Arkansas Volunteer Lawyers for the Elderly. He has also assisted in drafting State legislation affecting seniors, primarily in the guardianship area. David is going to talk to us about the Arkansas program.

STATEMENT OF DAVID MANLEY, DIRECTOR OF LITIGATION, LEGAL SERVICES OF ARKANSAS

Mr. MANLEY. Good afternoon. Hello from Arkansas. We are very proud of Senator Pryor in Arkansas. He is so popular in Arkansas, he's running unopposed this time. Nobody even wants to try to tackle him, and it's smart on their part, I can assure you.

Senator Pryor has been at the forefront of these issues for as long as I can remember back before he even became a Senator, back when he was the Governor of Arkansas and a newspaper editor, so we have a good person in charge of this, and we need to pay attention to what he says and what his concerns are.

I have a fairly lengthy written statement in the handout that I'm going to refer you to, and attached to that statement are several statistical, I guess, surveys from my program and from a program called Arkansas Volunteer Lawyers for the Elderly. I was asked to talk about statistics, but I can't think of anything more dull. I hate statistics, but I have provided the Committee and the staff and anyone else who would like those statistics about what kind of cases we see, what we're doing for the elderly, 60-plus, and what we just generally do in legal services.

I would like to go ahead and do a prepared statement, but at the end of that statement, I want to just throw out some issues that I have seen based upon what the ombudsmen have said and other concerns that we have attempted to address in Arkansas.

Prior to 1983, there was no organized program in Arkansas that dealt strictly with providing legal services to the elderly. Now, there are seven legal services programs in Arkansas, and each of those programs served the elderly only if they came through the door or asked for assistance on a particular legal problem. They weren't treated any differently than any other legal services eligible client.

About the end of 1983, maybe early 1984, one of the legal services programs, Central Arkansas Legal Services, that serves Little Rock and the central part of the State received some Title III money from the State agency on aging to provide pro bono legal services to the elderly. Now, that program had already established a pro bono program through the use of volunteer private attorneys to represent people with their legal problems, and they simply used that Title III money to help fund that particular program.

In late 1983 or early 1984, the young lawyers section of the Arkansas Bar Association got together and decided that they needed to address and establish a pro bono program that serves only the elderly, 60-plus. Now, Arkansas is second right behind Florida in the percentage of elderly that we have in the State.

We have a lot of retired folks, most of those are up in the northern part of the State in the retirement villages in the mountains, and we have just an incredible amount of rural poverty in our State. We are primarily a rural State, and there is an awful lot of poverty, and our elderly are some of the poorest people in our State.

But the Bar Association contacted the legal services programs and asked that we assist them in setting up a program, and we did that. They set up a 501(c)(3) nonprofit organization that now houses the legal services developer component of the State aging network. The board of directors of that program consists of the five legal services programs that help fund it, five attorneys from the private bar that are appointed by the President of the Arkansas Bar Association, one potentially eligible client and one representative of the State aging agency.

They currently have 544 attorneys that have agreed to participate on a pro bono basis. That, to me, is incredible, because most of the attorneys in Arkansas are located in the central part of the State, and I know there are probably law firms here in D.C. that have got more than 500 lawyers in the firm, but most of the attorneys in Arkansas are in the central part of the State, and they do not participate in that program. They have their own pro bono program.

So these are attorneys from the rural, 2,500 to 4,000 population, towns in Arkansas that have agreed to sign up and take three cases each year on behalf of simply an elderly person. Now, how they refer cases to the program is set out at length in my written statement. Generally, legal services refers elderly clients to the program, and then the local AAAs also refer clients to the program.

One of the things I'd like to hear some input on is the means test problem that we're having. We've never resolved it, we've simply fussed about it and talked about it. Legal services programs do not accept clients unless they're financially eligible, and they screen those people before they refer them to a volunteer pro bono organization.

This organization also receives referrals from the area agencies on aging. They're not allowed to screen individuals for income, and when I was legal counsel for the organization, I encouraged them as a matter of public policy or public relations to be real careful about who they refer to the private bar, because if a AAA referral comes through that organization and that person drives up to that attorney's office in a Mercedes wanting free legal services, you just can't have that. And I know the AAAs hands are tied.

It's generally the sentiment throughout the legal services community, not just Arkansas, but nationwide—and I'm certainly not here to speak for everybody in legal services, it's the general consensus throughout the legal services community, however, that the private bar is necessary to help provide legal services to the elderly.

The private bar should be a supplement to what the legal services programs are doing.

The systematic problems, I think those are better addressed by the legal services programs, and I particularly liked the comments earlier about the philosophy and the vision, what vision legal services have. Well, if we want to change some of these systematic problems, we're going to have to let the people who address those things on a regular basis do those and let the private bar help with providing the individual service work, and I don't think you'll get much fuss from the private bar on that, either.

We've got a law firm in Little Rock, it's a private law firm, that has been incredibly successful in suing nursing homes for the care that the residents are getting. So they can do some things, but legal services addresses systematic abuse issues every day, and it probably makes more sense logistically to let legal services continue to do those things.

Now, in Arkansas, we have eight area agencies on aging. Last year, all eight of those programs asked for waiver. Now, it's discouraging enough that none of them wanted to do it, but half of them got a waiver. The four that didn't get waivers have allocated the following amounts to legal assistance: $25, $500, $5,120, and $27,000. Upon information and belief, the $27,000 went to provide a full time attorney in-house, and that person had three cases for $27,000. They've since, I think, changed the way they're providing the legal assistance at that particular AAA.

Now, I'm going to refer you to my written comments and the statistics. I'm very impressed with Massachusetts. The weekly visits is inconceivable to me. Everything you said about the recommendations, those were all super. I wish we could do it everywhere. I feel the ombudsman is too spread out. I mean, there's a fairly detailed statement in the Act that talks about the role of the ombudsman. It's inconceivable that one person can do all that. I don't see how.

They may want to just cut back and really concentrate on what we learned in high school political science and college about the true role of an ombudsman, which is go in and find out what's wrong and try to work within the system to change things. I can't see how, especially in a rural State when you're on the road a lot visiting these nursing homes, how they could possibly do all the stuff that they're expected to do.

Service versus impact work. This goes, again, to Dr. Cohen's visions. I know the AAAs have not yet addressed what specific kinds of cases they need to be doing, but if more nursing homes consistently abuse residents or a particular problem occurs over and over again, you don't address each individual problem. You better look at the big picture and see why those things keep going on.

Volunteers. I liked the discussion this morning about the volunteers, and I'd like to develop that a little bit more on the questions and answer.

Ombudsmen needing legal representation if they're sued and needing legal advice. If it's the only person in the office, I'm not sure, how you would structure that. If the ombudsman is an attorney they'd be better off, or if they worked in close conjunction with legal services or a Title III funded program, they'd be much better off.

The first speaker this morning kind of depressed me because of the statistics about what we're not doing, and then as it went on, I got more and more encouraged that at least somebody out there is doing something good. I would refer you to some of the exhibits that I've attached about what we're doing and why we're doing it. Thank you.

[The prepared statement of David Manley follows:]

Testimony of David J. Manley to be given June 28, 1990 before the Senate Committee on Aging

Prior to 1983, there was no organized program in Arkansas the sole purpose of which was to provide legal services to elderly Arkansans. Although the seven Legal Services Corporation programs in Arkansas represented low income elderly clients, none of these programs had a component to address solely elderly issues or elderly clients. Some of the legal services programs had private bar involvement programs which paid members of the private bar a fixed hourly fee for representing legal services eligible clients of all ages. In 1984 Central Arkansas Legal Services (CALS) began receiving money from the State Office on Aging to help fund the Volunteer Organization of Central Arkansas Legal Services (VOCALS). The grant was made with Older Americans Act Title IIIB administrative funds and was to be used by VOCALS to represent socially and economically needy elderly clients in the Central Arkansas area. VOCALS, however, refers low income clients of all ages to private attorney volunteers and serves only the central part of the state.

In late 1983, the Young Lawyers Section of the Arkansas Bar Association organized Arkansas Volunteer Lawyers for the Elderly (AVLE). The sole purpose of AVLE is to provide pro bono legal services to elderly Arkansans. AVLE is unique in Arkansas because it is the only one of its kind to provide free legal assistance exclusively to low income, elderly Arkansans in 67 of the 75 Arkansas counties. With the exception of Florida, Arkansas has a higher percentage of elderly citizens than any other state in the country. Because Arkansas is a primarily rural state access to legal services is often difficult for the elderly, low income citizens of Arkansas.

AVLE is sponsored by the Arkansas Bar Association and funded by five of the seven legal services programs and the Arkansas Department of Human Services, Division of Aging and Adult Services. The AVLE program also encompasses the state legal services developer component from which it provides technical, educational and legal assistance and outreach to the aging network, primarily through regional Area Agencies on Aging and the State Ombudsman.

AVLE has a full time coordinator, who also acts as the Legal Services Developer, and a full time administrative assistant. Clients are screened for eligibility and the existence of a legal problem by the local legal services programs or by the local area agency on aging. After the client has been screened, the case is forwarded to the AVLE coordinator in Little Rock for referral to a member of the private bar who has previously agreed to participate in AVLE. To participate in AVLE, private bar attorneys agree to represent up to three low income, elderly Arkansans each year, free of charge. As of June, 1990 AVLE membership stands at 544 participating attorneys. This number represents approximately one fourth of the total bar association membership in AVLE's service area.

When a client is referred to AVLE from either a legal services program or an area agency on aging, the coordinator notes the client's locale and attempts to find a participating attorney in the client's county of residence, or in the county where the legal problem exist. Upon referral, each case is monitored and reviewed until closed at which time the AVLE coordinator reports the disposition of the case to the referring agency.

In February 1986, AVLE was incorporated and in May, 1986 AVLE received 501(c)(3) tax exempt status from the federal government. This non-profit status affords the organization the opportunity to seek outside funding for special projects, such as training, that would directly result in the provision of free legal services to greater numbers of low income, elderly Arkansans.

AVLE's Board of Directors includes five private bar attorneys appointed by the Arkansas Bar Association, the Executive Directors of the five state legal services programs who help fund AVLE, one representative of the Division of Aging and Adult Services, and one potentially eligible client representative. The Board of Directors meets quarterly and has direct control over the budget, personnel and policies of AVLE. In addition, Board Members assist the AVLE staff with attorney recruitment, funding and community education.

Training on elderly issues and poverty law support have become vital and important components of the AVLE program. Every attorney who agrees to participate in AVLE receives a complimentary Poverty Law Practice Manual. This is a 400-page manual which is periodically updated with current case law and legislation relevant to poverty law.

A regular program of free or substantially reduced fee-training seminars are provided each year. The trainings held at least twice a year are sponsored by the Arkansas Legal Services Support Center and cover such areas as civil procedure, advanced Social Security/SSI, public benefits, institutional care, nursing home law (proposed), federal practice, and family law. In January, 1990 the AVLE program co-sponsored a training with the American Bar Association, Commission on Legal problems for the Elderly, the National Senior Citizens Law Center, the American Association of Retired Persons, and the U.S. Equal Employment Opportunity Commission on age discrimination.

As a supplement to the Poverty Law Practice Manual, AVLE attorneys are encouraged to use the expertise of legal services attorneys in the field programs, at the Arkansas Legal Services Support Center and at the National Support Centers. As part of a 1990 grant awarded AVLE by the Arkansas Interest on Lawyer's Trust Account Foundation (IOLTA), AVLE will develop an elder law database and quarterly newsletter to keep AVLE attorneys apprised of recent changes in elder law.

The primary reason for the success of AVLE is a close working relationship between the Arkansas Bar Association membership, the various legal services programs, and the State Aging network. The volunteer time given to the organizational, planning and recruitment aspects of AVLE by past and present members of the Young Lawyers Section of the Association, as well as past and current officers and members of the Arkansas Bar Association has been invaluable. The expertise, influence and energy of the private bar is a tremendous resource for meeting the legal needs of the elderly.

It is the sentiment throughout the legal services community that pro bono attorneys have been tremendously helpful in providing legal services to poor people of all ages and specifically the low-income elderly in Arkansas. The contributions of the private bar are generally viewed as supplemental in nature, however, and should not be expected to meet a core need for legal assistance.

The most important reason for this is that private bar attorneys cannot be expected to be well-versed in areas of poverty law as it pertains to the elderly. Law that deals primarily with public benefits and entitlement programs such as Social Security Old Age and Disability benefits, SSI, VA benefits, and Medicaid are rapidly changing, complex areas that private attorneys have not traditionally practiced. These areas of the law have been, almost exclusively, addressed by legal services programs.

Arkansas has been innovative in its approach to meeting the legal needs of the elderly. We have not been completely successful, however, because there is a substantial unmet need, as evidenced by the attached portion of an Arkansas longitudinal study conducted in 1988 for the Arkansas Department of Human Services, Division of Aging and Adult Services. (Exhibit No. 2) According to the study, approximately 14,000 Arkansans age 60+ identified themselves as having a legal need which is unmet.

Attached is a copy of the "Priority Service Requirement" from the DHS, Division of Aging and Adult Services' State Plan. (Exhibit No. 4) This part of the plan sets out the priority areas for which Title IIIB funds must be allocated. The "Priority Service Requirement" also addresses the circumstance under which a waiver request will be considered. An area agency on aging must "demonstrate that these services can be supplied in an adequate proportion from other funding sources." In spite of the longitudinal study suggesting a substantial unmet need exist, in fiscal year 1989-90, four of the eight state area agencies on aging were granted waivers from providing any legal services. Of the four agencies not granted waivers, the following sums were appropriated: $25.00; $500.00; $5,120.00; $27,000.00 (salary and fringe for in-house attorney).

Arkansas requested, and received in February, 1990 a technical assistance site visit from The Center for Social Gerontology. Executive Directors of legal services programs and area agencies on aging, along with AAA advocates, ombudsman and legal services pro bono coordinators met with representatives from the state office on aging to receive training and support on the Older Americans Act requirements for the provision of legal services. The end result was that recommendations for corrective measures were drafted and submitted to the Deputy Director of DHS, Division of Aging and Adult Services. Those recommendations are attached. (Exhibit No. 3)

Fortunately, shortly after the Reagan administration budget cuts to legal services programs, the Young Lawyers Section of the Arkansas Bar Association had the foresight to recognize the need for private attorney involvement in rendering legal services to poor people. They also had the foresight to realize that one of the greatest special needs area would be the growing elderly population existing on a fixed income.

Also attached to the transcript of my prepared statement are some statistics which set forth the age of the elderly population in Arkansas that is low income and potentially eligible for free legal services, the types of cases which have been handled by AVLE attorneys and legal services attorneys on behalf of the elderly, and other statistical information that may be of some benefit to the committee and its staff. (Exhibit Nos. 5-19)

INDEX OF EXHIBITS

EXHIBIT #	
1	AVLE Brochure
2	Arkansas Longitudinal Study (1988)
3	Legal Assistance Site Visit Recommendations (undated but sent to State Office of Aging in February, 1990)
4	Priority Service Requirement (page 38 of the Arkansas State Plan for 1989 - 1990)
	STATISTICS
5	Referrals to AVLE by Legal Services Programs (1/1/90 - 5/31/90)
6	Referrals to AVLE by Area Agencies on Aging (1/1/90 - 5/31/90)
7	AVLE Referrals by County and Age (all sources) (1/1/90 - 6/21/90)
8	LSA Applicants 60 and Over Denied by Type Case (1989)
9	LSA Applicants 60 and Over Accepted by LSA Staff by Type Case (1989)
10	LSA Applicants 60 and Over Referred to AVLE by Type Case (1989)
11	LSA Applicants 60 and Over and Disposition by County (1989)
12	LSA Applicants 60 and Over Denied by Type Case (1/1/90 - 05/31/90)
13	LSA Applicants 60 and Over Accepted by LSA staff by Type Case (1/1/90 - 5/31/90)
14	LSA Applicants 60 and Over referred to AVLE by Type Case (1/1/90 - 5/31/90)
15	LSA Applicants 60 and Over and Disposition by County (1/1/90 - 5/31/90)
16	LSA Clients (All Ages) Whose Cases Were Closed in 1989 by Type Case (Private Attorney Involvement)
17	LSA Clients (All Ages) Whose Cases Were Closed in 1989 by Type Case (Staff Cases)
18	LSA Clients (All Ages) Whose Cases Were Closed from 1/1/90 - 3/31/90 by Type Case (Private Attorney Involvement)
19	LSA Clients (All Ages) Whose Cases Were Closed from 1/1/90 - 3/31/90 by Type Case (Staff Cases)

Arkansas Longitudinal St.
2nd Wave D 1988

TABLE 5-53

CURRENT USE AND NEED FOR SERVICES
BY AGE COHORT
(ALL ELDERS)

SERVICES	55-59	60-64	65-69	70-74	75-79	80-84	85+	AR
Legal Services								
Current Use	3.9	4.9	5.0	4.5	4.4	4.3	3.2	4.5
Unmet Need	1.3	3.0	2.5	3.9	3.3	2.6	2.4	2.8
Case Management[1]								
Current Use	.9	1.1	2.9	4.3	6.0	10.7	10.3	4.2
Unmet Need	2.2	5.4	4.3	3.9	7.7	4.3	6.3	4.7
Transportation[1]								
Unmet Need	3.9	1.1	4.5	7.6	7.7	9.9	11.1	5.9
Noon Meal At Senior Center[1]								
Current Use	.9	3.3	5.2	7.6	11.0	8.6	11.1	6.2
Unmet Need	1.3	1.6	.7	.6	2.2	1.3	4.0	1.4
Health Education or Activity Program								
Current Use	3.4	4.1	2.9	3.0	2.2	1.7	1.6	2.9
Unmet Need	1.3	1.1	---	.2	1.4	.4	1.6	.7
Home-Delivered Noon Meal[1]								
Current Use	.4	.5	1.8	2.2	3.3	6.9	8.7	2.6
Unmet Need	---	1.1	.9	1.1	4.1	6.0	6.3	2.1
Counseling[3]								
Current Use	2.6	.5	1.4	.4	.3	.4	1.6	1.0
Unmet Need	1.3	1.9	.2	.4	1.9	1.3	1.6	1.1
In-Home Skilled Nursing[4]								
Current Use	---	1.1	1.4	1.7	2.5	2.6	4.8	1.7
Unmet Need	.9	2.4	1.4	1.7	2.7	1.3	2.4	1.8
Employment Training[1]								
Current Use	4.7	.8	.7	.2	.3	---	---	1.1
Unmet Need	1.3	.5	.5	.2	1.1	.4	1.6	.7
Respite Care[1]								
Current Use	.4	---	.2	.2	.8	1.3	.8	.4
Unmet Need	.4	.3	.2	.2	.5	.4	4.0	.5
Nursing Home[2]								
May Need	.4	.8	2.0	1.9	2.7	6.0	5.6	2.3
Day Care								
Current Use	---	---	.2	---	---	---	---	---
Unmet Need	.4	.3	.5	.2	.8	.4	2.4	.5
Caregiver Support Group[3]								
Current Use	---	---	---	.2	---	.9	---	.1
Unmet Need	---	---	.2	.2	1.1	.4	1.6	.4
Number	360	368	444	462	364	233	126	2357

---

[1] Chi Square significant at the .0001 level
[2] Chi Square significant at the .001 level
[3] Chi Square significant at the .01 level
[4] Chi Square significant at the .05 level

TABLE 5-54

CURRENT USE AND NEED FOR SERVICES BY RACIAL/ETHNIC GROUP (ALL ELDERS)

% of Elders in Racial/Ethnic Group

SERVICES	WHITE	OTHER	AR
Legal Services			
Current Use	4.9	3.5	4.7
Unmet Need	2.8	2.1	2.7
Case Management[1]			
Current Use	3.3	9.9	4.2
Unmet Need	4.3	7.4	4.7
Transportation[1]			
Unmet Need	4.9	13.4	6.1
Noon Meal At Senior Center			
Current Use	6.1	6.0	6.1
Unmet Need	1.4	1.8	1.4
Health Education or Activity Program			
Current Use	2.5	3.5	2.6
Unmet Need	.6	1.1	.6
Home-Delivered Noon Meal[2]			
Current Use	2.2	4.9	2.6
Unmet Need	1.8	4.9	2.3
Counseling			
Current Use	.8	.7	.8
Unmet Need	1.0	1.4	1.0
In-Home Skilled Nursing[3]			
Current Use	1.2	4.2	1.6
Unmet Need	2.0	1.1	1.9
Employment Training			
Current Use	.9	.4	.8
Unmet Need	.6	1.1	.6
Respite Care			
Current Use	.3	1.1	.4
Unmet Need	.5	1.1	.6
Nursing Home			
May Need	2.2	2.5	2.3
Day Care			
Current Use	---	---	---
Unmet Need	.6	.7	.6
Caregiver Support Group[4]			
Current Use	---	.4	.0
Unmet Need	.4	.7	.4
Number	1740	283	2023

---

[1] Chi Square significant at the .0001 level
[2] Chi Square significant at the .001 level
[3] Chi Square significant at the .01 level
[4] Chi Square significant at the .05 level

TABLE 5-55

CURRENT USE AND NEED FOR SERVICES
BY SEX
(ALL ELDERS)

	Percentage of Elders in Sex Type		
SERVICES	MALE	FEMALE	AR
Legal Services			
Current Use	4.3	4.5	4.4
Unmet Need	2.3	3.1	2.8
Case Management[1]			
Current Use	2.6	5.2	4.2
Unmet Need	3.1	5.5	4.6
Transportation[1]			
Unmet Need	2.9	7.7	5.8
Noon Meal At Senior Center[3]			
Current Use	4.3	7.4	6.2
Unmet Need	1.3	1.4	1.4
Health Education or Activity Program[2]			
Current Use	1.3	3.9	2.9
Unmet Need	.3	1.0	.7
Home-Delivered Noon Meal[3]			
Current Use	1.6	3.1	2.5
Unmet Need	1.4	2.5	2.1
Counseling[4]			
Current Use	.6	1.1	.9
Unmet Need	.5	1.5	1.1
In-Home Skilled Nursing			
Current Use	1.1	2.0	1.6
Unmet Need	1.2	2.0	1.7
Employment Training			
Current Use	.9	1.2	1.1
Unmet Need	.2	.9	.6
Respite Care			
Current Use	.3	.4	.4
Unmet Need	.3	.7	.5
Nursing Home			
May Need[3]	2.0	2.4	2.2
Don't Know	4.7	2.0	3.1
Day Care			
Current Use	.1	---	---
Unmet Need	.4	.6	.5
Caregiver Support Group			
Current Use	---	.2	.1
Unmet Need	.4	.3	.4
Number	929	1452	2381

[1] Chi Square significant at the .0001 level
[2] Chi Square significant at the .001 level
[3] Chi Square significant at the .01 level
[4] Chi Square significant at the .05 level

TABLE 5-56

CURRENT USE AND NEED FOR SERVICES BY STATE AND AAA REGION (ALL ELDERS)

Percentage of Elders in Region/State

Services	I	II	III	IV	V	VI	VII	VIII	AR*
Legal Services									
Current Use	5.6	3.5	2.9	5.1	5.1	3.8	5.7	2.6	4.4
Unmet Need	3.2	2.9	4.7	2.5	2.5	3.8	2.8	1.9	2.9
Case Management[3]									
Current Use	5.6	4.4	6.9	3.1	4.3	3.4	4.9	2.6	4.3
Unmet Need	6.4	4.4	5.8	5.6	3.1	5.7	6.1	1.1	4.8
Transportation[3]									
Unmet Need	7.5	3.0	7.3	5.7	4.8	4.3	6.8	3.8	5.3
Noon Meal At Senior Center[2]									
Current Use	9.2	7.3	5.1	3.7	7.0	5.7	5.7	8.6	6.4
Unmet Need	3.2	--	2.5	2.0	.8	1.9	.4	.4	1.4
Health Education or Activity Program									
Current Use	1.6	2.9	2.2	2.0	4.3	3.4	2.8	3.4	2.8
Unmet Need	.8	1.3	.4	1.1	---	1.1	.8	---	.7
Home-Delivered Noon Meal[1]									
Current Use	1.6	3.5	1.1	2.8	1.6	3.1	2.4	4.5	2.6
Unmet Need	4.8	.3	4.0	2.4	2.7	1.9	.4	.7	2.1
Counseling									
Current Use	0.8	1.3	1.4	1.1	.4	.4	.8	.4	.9
Unmet Need	.8	1.6	1.8	1.4	1.6	1.1	.4	---	1.1
In-Home Skilled Nursing									
Current Use	1.2	2.2	2.5	1.1	1.2	2.3	1.6	.7	1.6
Unmet Need	2.4	2.5	2.2	1.1	1.6	2.7	1.6	---	1.7
Employment Training									
Current Use	1.6	1.9	---	.3	1.2	1.8	.4	1.7	1.9
Unmet Need	.4	---	1.1	.6	.4	1.5	.8	.4	.6
Respite Care									
Current Use	.4	.3	.4	.6	.4	---	---	.7	.4
Unmet Need	1.2	.6	---	.8	---	.4	.8	.4	.5
Nursing Home May Need	3.7	3.1	1.9	1.7	1.0	2.3	2.8	.6	2.1
Day Care									
Current Use	---	---	---	---	---	.4	---	---	---
Unmet Need	1.6	.3	---	.8	---	.4	.8	.4	.5
Caregiver Support Group									
Current Use	---	---	.4	.3	---	---	---	.4	.1
Unmet Need	.8	.6	.4	.3	---	.4	.4	.4	.4
Number	250	315	277	355	257	2623	247	268	2231

[1] Chi Square significant at the .0001 level
[2] Chi Square significant at the .01 level
[3] Chi Square significant at the .05 level

*Table constructed from smaller data files joined for Wave I & Wave II.

DAAS Senior Center
Study\April 1989

SENIOR SURVEY RESULTS

REGION 1
Did not respond.

REGION 2
16 out of 32 responded (50%)
Order of Importance: 1. Medical Specialists
Tie 2. Supp. Insurance
Fraud
Legislative Issues
3. Stress Management
4. Legal Issues

REGION 3
20 out of 38 responded (53%)
Order of Importance: 1. Legislative Issues
Tie 2. Supplemental Insurance
Medical Specialists
Tie 3. Stress Management
Fraud
4. Legal Issues

REGION 4
19 out of 20 responded (95%)
Order of Importance: 1. Medical Specialists
Tie 2. Supplemental Insurance
Fraud
Legislative Issues
3. Stress Management
4. Legal Issues

REGION 5
15 out of 25 responded (60%)
Order of Importance: 1. Supplemental Insurance
Tie 2. Medical Specialists
Legislative Issues
3. Stress Management
Tie 4. Legal Issues
Fraud

REGION 6
11 out of 14 responded (79%)
Order of Importance: 1. Supplemental Insurance
2. Medical Specialists
Tie 3. Legal Issues
Fraud
Tie 4. Legal Issues
Stress Management

REGION 7
21 out of 39 responded (54%)
Order of Importance: 1. Legislative Issues
Tie 2. Supplemental Insurance
3. Fraud
4. Legal Issues
5. Medical Specialists
6. Stress Management

REGION 8
24 out of 24 responded (100%)
Order of Importance: 1. Supplemental Insurance
2. Legal Issues
Tie 3. Legislative Issues
Medical Specialists
4. Stress Management
5. Fraud

Overall, 124 out of 207 surveys were returned (60%).

WRITE-IN SUGGESTIONS
Region 2: Suicide Prevention in the Elderly
Region 3: Nursing Home Care
Exercise & Crafts
Region 6: Adult Education - Reading
Region 8: Cost Saving Benefits for Sr. Citizens (low income housing, food stamps etc.)
Discounts for Sr. Citizens (travel etc.)

LEGAL ASSISTANCE SITE VISIT RECOMMENDATIONS

1. Due to an unmet legal assistance need, as identified in the Longitudinal Study and a Senior Center Survey, it is recommended that the State not grant AAA waivers for this priority category.

2. When considering waivers, the State should scrupulously review targeting and outreach efforts to ascertain how identified unmet legal assistance needs are being met.

3. The State should set a minimum percentage of 5% for each AAA to allocate for legal assistance in FY 91. This percentage should rise to 8% by FY 93.

4. While developing the legal assistance programs with Title IIIB funds, the State should require of AAAs a minimum maintainance of effort, year to year. Additionally, the State should not abandon its funding of the pro bono effort(CALS/AVLE) utilizing State administrative funds.

5. A meeting of all AAA and LSC directors, with DAAS staff and pro bono providers, should be held to discuss legal assistance issues and to share information regarding current efforts to provide legal assistance.

6. The State should consider the formation of a statewide network of AAA, LSC, DAAS and pro bono provider staff to provide ongoing training in public benefits and other legal assistance matters. This network would also share information about current program efforts, targeting priorities and outreach plans for the socially and economically needy and low income minority elderly.

7. The methods of targeting the socially and economically needy for legal assistance needs to be more specific than the general method adopted for all services. The Request for Proposals(RFP) for legal assistance should contain these more specific methods, including the use of case priorities to target the desired clients. The RFP method should also contain the provision that the percentage of minority clients served be equal to at least that percentage of minority elderly in the planning and service area.

8. The State Director is encouraged to meet with all AAA directors to discuss these recommendations and the legal assistance effort in general.

Exhibit

#3

Priority Service Requirement

In accordance with section 307 (a) (22), the State Agency requires that the Title III_B allotment to each Area Agency on Aging be spent as follows:

In the absence of a waiver, 50% of the total Title III_B allotment is to be spent in:

1. Services Associated with Access to Services
2. In-Home Services
3. Legal Assistance
4. Advocacy Assistance
5. Nursing Home Ombudsman

For categories 3, 4 and 5 at least 10% of the total allotment of Title III_B must be spent in these services.

For categories 1 and 2 no less than 5% may be spent in each service.

An Area Agency on Aging may request a waiver of this requirement in its area plan if it can demonstrate that these services can be supplied in an adequate proportion from other funding sources. Each Area Agency must have a public hearing on this waiver request prior to submission of the Area Plan and forward a record of the public hearing at the time of plan submission.

Exhibit

#4

AVLE MONTHLY REPORT

	EALS	LSA	LSNEA	OLS	WALS	TOTAL
CONSUMER/FINANCE						
01 Bankruptcy/Debtor Relief	1	3	1			5
02 Collection		1	1	1		3
03 Contracts/Warranties			1			1
04 Credit Access						
05 Energy						
06 Loans						
07 Public Utilities						
08 Unfair Sales Practice		1			1	2
09 Other Consumer/Finance	2	1				3
EMPLOYMENT						
21 Job Discrimination						
22 Wage Claims						
29 Other employment						
FAMILY						
30 Adoption	1					1
31 Custody/Visitation	1					1
32 Divorce		1	1	2		4
33 Guardianship					1	1
34 Name Change	1					
36 Paternity						
38 Support						
39 Other family						
HEALTH						
51 Medicaid						
52 Medicare						
59 Other Health	1		1			2
HOUSING						
61 Federally Sub Housing						
62 Homeownership/Real Prop.	1	2	1	3	2	9
63 Landlord/tenant						
64 Other Public Housing						
69 Other housing						
INCOME MAINTENANCE						
71 AFDC/Other welfare						
73 Food Stamps						
76 Unemployment Comp						
77 Veterans Benefits						
78 Worker's Comp						
79 Other Income Maintenance						
MISCELLANEOUS						
94 Torts		1			1	2
95 Wills/estates	2			1		3
99 Other Miscellaneous	1					1
______ MONTHLY TOTAL (LSC)	11	9	7	7	6	39
(AAA)						7
YEAR TO DATE (LSC)						174
YEAR TO DATE (AAA)						37
MONTHLY RETURN (LSC)	2					2
MONTHLY RETURN (AAA)						0
* TOTAL YEAR TO DATE						211

	EALS	LSA	LSNEA	OLS	WALS
* PROGRAM YEAR TO DATE	27	65	34	20	29

AREA AGENCIES ON AGING REFERRALS

EAAAAA

Bankruptcy	1
Consumer	1
Adoption	1
Custody	1
TOTAL	4
YTD	17

NWAAAA

Guardianship	1
will	1
TOTAL	2
YTD	9

WAAAA

Property	1
TOTAL	1
YTD	2

Month May, 1990 Total 7 YTD 37

Exhibit

#7

```
CLIENT'S BY AGE FROM 1/1/90 TO 6/21/90
Casenum...  Age


VB-90-0073    0
----------  ---
        1C    0

WH-90-1516   51
----------  ---
        1C   51

CR-90-0071   55
LE-90-0070   55
PE-90-1546   55
SF-90-0083   55
LA-90-0089   55
CO-90-1081   55
CR-90-0119   55
MI-90-0150   55
----------  ---
        8C   55

UN-90-1014   56
PS-90-0028   56
CR-90-0034   56
SB-90-0036   56
WH-90-1537   56
PO-90-0019   56
FR-90-0101   56
BR-90-0590   56
PO-90-0067   56
----------  ---
        9C   56

AS-90-0507   57
WH-90-1511   57
DE-90-0527   57
PR-90-1531   57
IN-90-0054   57
WA-90-0106   57
AS-90-0573   57
MI-90-0112   57
MI-90-0141   57
CR-90-0120   57
WA-90-0133   57
----------  ---
       11C   57

CH-90-0506   58
CR-90-0023   58
PP-90-0027   58
PH-90-0055   58
CW-90-0064   58
PR-90-1552   58
PP-90-0107   58
CO-90-1110   58
----------  ---
        8C   58

JA-90-0047   59
LI-90-0540   59
MO-90-0020   59
GN-90-0080   59
DA-90-1082   59
PH-90-0102   59
GR-90-1580   59
SB-90-0105   59
CT-90-0111   59
MI-90-0118   59
MI-90-0152   59
----------  ---
       11C   59

CA-90-0021   60
PR-90-1540   60
RR-90-0059   60
CR-90-0087   60
CS-90-0104   60
JA-89-0059   60
SC-90-0135   60
CE-90-0137   60
----------  ---
        8C   60
```

```
IN-90-0005   61
IN-90-0009   61
WA-90-0022   61
OU-90-1028   61
PP-90-0024   61
CA-90-0042   61
JA-90-0049   61
LA-90-0063   61
SB-90-0092   61
CA-90-0102   61
GN-90-0121   61
----------  ---
       11C   61

AR-89-0159   62
UN-90-1022   62
LA-90-0026   62
MR-90-0058   62
PP-90-0032   62
PO-90-0014   62
SB-90-0060   62
CR-90-0072   62
PP-90-0081   62
AS-90-0555   62
WA-90-0097   62
MI-90-0113   62
CR-90-0129   62
DR-90-0597   62
----------  ---
       14C   62

CA-90-0020   63
JA-90-0043   63
UN-90-1073   63
CR-90-0088   63
MI-90-0096   63
SB-90-0125   63
CT-90-0132   63
----------  ---
        7C   63

JN-90-0006   64
SB-90-0004   64
WA-90-0016   64
WA-90-0017   64
CO-90-1023   64
SH-90-0030   64
YE-90-0031   64
JN-90-0040   64
PE-90-1547   64
DR-90-0054   64
RD-90-0086   64
JA-90-0114   64
MO-90-0046   64
PS-90-0130   64
----------  ---
       14C   64

UN-90-1001   65
SF-90-0033   65
CH-90-0041   65
CT-90-0091   65
YE-90-0103   65
BN-90-0116   65
SB-90-0124   65
WH-90-1605   65
----------  ---
        8C   65

VB-90-0002   66
LE-90-0044   66
SF-90-0066   66
LA-90-0085   66
SB-90-0084   66
WA-90-0093   66
WA-90-0117   66
MI-90-0148   66
----------  ---
        8C   66
```

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BR-89-0501   67
GN-90-0077   67
CO-90-1070   67
CA-90-0101   67
WO-90-0149   67
----------  ---
        5C   67

MI-90-0013   68
BN-90-0046   68
JN-90-0074   68
BO-90-0082   68
WH-90-1575   68
BR-90-0569   68
WH-90-1596   68
JA-90-0134   68
NW-90-0136   68
PH-90-0140   68
PS-90-0154   68
----------  ---
       11C   68

MI-90-0001   69
CR-90-0012   69
GR-90-1562   69
WA-90-0103   69
SB-90-0104   69
CE-90-0105   69
DR-90-0580   69
CL-90-0581   69
----------  ---
        8C   69

SB-90-0010   70
SB-90-0011   70
PP-90-0014   70
WH-90-1560   70
JA-90-0142   70
MI-90-0153   70
----------  ---
        6C   70

LI-90-0500   71
AR-90-1525   71
UN-90-1025   71
HO-90-0018   71
IN-90-0069   71
UN-90-1069   71
UN-90-1122   71
SB-90-0145   71
----------  ---
        8C   71

BN-90-0007   72
IN-90-0038   72
PO-90-0013   72
PR-90-0075   72
PP-90-0110   72
CR-90-0123   72
----------  ---
        6C   72

WH-89-0294   73
LA-90-0029   73
SB-90-0053   73
SB-90-0056   73
Sf-90-0076   73
PH-90-0095   73
FR-90-0109   73
CT-90-0131   73
SB-90-0139   73
----------  ---
        9C   73

PS-90-0018   74
BN-90-0051   74
BO-90-0109   74
LA-90-0115   74
CR-90-0138   74
```

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CLIENT'S BY AGE FROM 1/1/90 TO 6/21/90
Casenum...  Age


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        5C  74

MO-90-0029   75
BO-90-0078   75
AR-90-1554   75
SB-90-0098   75
SB-90-0106   75
CR-90-0144   75
----------  ---
        6C  75

MI-90-0025   76
PS-90-0061   76
SB-90-0067   76
BO-90-0079   76
GR-90-1563   76
UN-90-1140   76
----------  ---
        6C  76

PS-90-0003   77
WH-90-1509   77
CL-90-0528   77
MO-90-0044   77
LA-90-0108   77
CR-90-0128   77
----------  ---
        6C  77

SB-90-0037   78
CT-90-0057   78
CO-90-1539   78
BN-90-0108   78
----------  ---
        4C  78

GN-90-0008   79
PH-90-0099   79
WA-90-0122   79
PS-90-0143   79
WA-90-0146   79
----------  ---
        5C  79

CE-90-0019   80
SB-90-0015   80
CT-90-0052   80
RD-90-0068   80
UN-90-1078   80
CW-90-1555   80
OU-90-1107   80
----------  ---
        7C  80

SE-90-0021   81
----------  ---
        1C  81

BN-90-0045   83
DR-90-0090   83
----------  ---
        2C  83

PO-90-0031   84
LE-90-0094   84
UN-90-1093   84
MA-90-0100   84
OU-90-1098   84
SF-90-0126   84
WH-90-1610   84
----------  ---
        7C  84

CO-90-1048   85
----------  ---
        1C  85
```

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CLIENT'S BY AGE FROM 1/1/90 TO 6/21/90
Casenum...  Age

JN-90-0062   87
----------  ---
        1C   87

SB-90-0147   88
----------  ---
        1C   88

JN-90-0065   91
----------  ---
        1C   91

RD-90-0050   96
SB-90-0107   96
----------  ---
        2C   96

      227C
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LEGAL SERVICES OF ARKANSAS, INC.
1989 REJECTIONS - 60+

	BLACK			WHITE			
	F	M	T	F	M	T	GT
Type Problem							
Bankruptcy/Debtor Relief	0	0	0	1	1	2	2
Collect/Repo/Defic/Garn.	0	2	2	4	5	9	11
Contracts/Warranties	1	1	2	1	2	3	5
Credit Access	0	1	1	0	1	1	2
Loans/Install Pur.	0	1	1	0	0	0	1
Public Utilities	0	0	0	0	1	1	1
Unfair Sales Practice	0	0	0	0	2	2	2
Other Consumer/Finance	1	0	1	1	0	1	2
Custody/Visitation	0	0	0	1	0	1	1
Divorce	0	3	3	6	0	6	9
Guardianship/Conserv.	0	0	0	3	2	5	5
Name Change	0	0	0	1	0	1	1
Other Family	0	0	0	1	1	2	2
Medicaid	0	1	1	0	0	0	1
Other Health	1	0	1	0	0	0	1
Homownership/Real Prop.	3	0	3	1	6	7	10
Food Stamps/Commodities	0	1	1	0	1	1	2
Social Security	0	2	2	1	0	1	3
SSI/SSD	0	1	1	0	0	0	1
Unemployment Compensation	0	0	0	0	1	1	1
Other Income Maintenance	0	0	0	0	1	1	1
License (Auto & Other)	1	0	1	0	0	0	1
Torts	3	1	4	5	4	9	13
Wills/Estates	1	0	1	7	4	11	12
Other Miscellaneous	4	2	6	1	1	2	8
	15	16	31	34	33	67	98

	NATIVE AMERICAN			
	F	M	T	GT
Other Family	0	1	1	1
				99

Exhibit

#8

LEGAL SERVICES OF ARKANSAS, INC.
1989 STAFF - 60+

	BLACK			WHITE			
	F	M	T	F	M	T	GT
Type Problem							
Bankruptcy/Debtor Relief	0	0	0	1	1	2	2
Collect/Repo/Defic/Garn.	3	3	6	3	2	5	11
Contracts/Warranties	3	1	4	2	1	3	7
Loans/Install Pur.	0	0	0	1	0	1	1
Unfair Sales Practice	0	0	0	0	1	1	1
Other Consumer/Finance	0	1	1	0	0	0	1
Other Employment	0	0	0	1	0	1	1
Adoption	0	0	0	3	0	3	3
Custody/Visitation	0	1	1	2	1	3	4
Divorce	0	0	0	1	1	2	2
Guardianship/Conserv.	3	0	3	6	1	7	10
Support	0	0	0	2	0	2	2
Other Family	1	0	1	2	3	5	6
Neglected/Abused/Dependent	1	0	1	1	0	1	2
Medicaid	3	1	4	8	1	9	13
Other Health	0	0	0	1	0	1	1
Fed. Sub. Housing Rights	1	0	1	1	1	2	3
Homownership/Real Prop.	4	4	8	7	6	13	21
Landlord/Tenant	0	0	0	0	3	3	3
Other Housing	1	1	2	0	0	0	2
AFDC/Other Welfare	1	0	1	2	0	2	3
Food Stamps/Commodities	2	1	3	2	0	2	5
Social Security	4	1	5	1	0	1	6
SSI/SSD	13	2	15	11	2	13	28
Unemployment Compensation	0	0	0	1	0	1	1
Veterans Benefits	1	0	1	1	0	1	2
Other Individual Rights	0	1	1	1	2	3	4
License (Auto & Other)	0	0	0	0	1	1	1
Torts	1	1	2	2	3	5	7
Wills/Estates	2	0	2	6	1	7	9
Other Miscellaneous	3	2	5	4	0	4	9
	47	20	67	73	31	104	171

	HISPANIC			
	F	M	T	GT
Medicaid	1	0	1	1
				172

Exhibit
#10

LEGAL SERVICES OF ARKANSAS, INC.
1989 AVLE - 60+

	BLACK			WHITE			
	F	M	T	F	M	T	GT
Type Problem							
Bankruptcy/Debtor Relief	1	0	1	1	0	1	2
Collect/Repo/Defic/Garn.	0	2	2	1	2	3	5
Unfair Sales Practice	0	1	1	0	0	0	1
Other Consumer/Finance	1	0	1	0	0	0	1
Adoption	3	1	4	4	0	4	8
Custody/Visitation	0	0	0	2	0	2	2
Divorce	2	0	2	5	4	9	11
Guardianship/Conserv.	3	1	4	2	3	5	9
Name Change	0	0	0	1	0	1	1
Paternity	0	0	0	0	1	1	1
Support	0	0	0	2	0	2	2
Other Family	1	0	1	0	0	0	1
Medicaid	1	0	1	1	0	1	2
Homownership/Real Prop.	4	0	4	6	2	8	12
Other Housing	0	2	2	0	0	0	2
SSI/SSD	1	0	1	0	0	0	1
Veterans Benefits	2	0	2	1	0	1	3
Torts	3	0	3	2	0	2	5
Wills/Estates	6	0	6	8	0	8	14
Other Miscellaneous	2	0	2	1	2	3	5
	30	7	37	37	14	51	88

	NATIVE AMERICAN			
	F	M	T	GT
Other Family	0	1	1	1
				89

Exhibit
#11

LEGAL SERVICES OF ARKANSAS, INC.
1989 REJECTIONS, STAFF AND AVLE BY COUNTY - 60+

	REJECTIONS	STAFF	AVLE	GTOTAL
County				
Arkansas	6	16	8	30
Ashley	5	11	5	21
Bradley	1	10	3	14
Calhoun	1	2	0	3
Chicot	6	8	3	17
Cleveland	1	1	0	2
Columbia	2	7	3	12
Conway	2	6	5	13
Dallas	0	3	5	8
Desha	2	9	6	17
Drew	9	14	4	27
Grant	3	6	4	13
Howard	7	3	1	11
Lincoln	0	1	2	3
Montgomery	3	7	0	10
Nevada	2	0	0	2
Ouachita	5	8	1	14
Perry	1	3	6	10
Pike	1	0	0	1
Polk	9	11	3	23
Prairie	3	1	1	5
Sevier	5	6	7	18
Union	15	24	8	47
White	10	15	14	39
Totals	99	172	89	360

Exhibit
#12

LEGAL SERVICES OF ARKANSAS, INC.
1990* REJECTIONS - 60+
*January - May, 1990

	BLACK			WHITE			
	F	M	T	F	M	T	GT
Type Problem							
Bankruptcy/Debtor Relief	0	0	0	1	0	1	1
Collect/Repo/Defic/Garn.	0	1	1	1	2	3	4
Contracts/Warranties	0	0	0	2	0	2	2
Credit Access	0	1	1	0	0	0	1
Other Consumer/Finance	0	1	1	0	0	0	1
Adoption	1	0	1	1	0	1	2
Custody/Visitation	1	0	1	0	1	1	2
Divorce	0	2	2	2	6	8	10
Guardianship/Conserv.	0	1	1	1	1	2	3
Other Family	1	0	1	1	2	3	4
Medicaid	0	0	0	2	0	2	2
Medicare	0	0	0	0	1	1	1
Homownership/Real Prop.	1	2	3	0	1	1	4
Landlord/Tenant	0	1	1	1	0	1	2
Other Public Housing	0	0	0	1	0	1	1
Other Housing	0	0	0	1	0	1	1
SSI/SSD	1	1	2	1	0	1	3
Workers Compensation	0	0	0	1	0	1	1
Torts	0	0	0	3	2	5	5
Wills/Estates	1	0	1	2	0	2	3
Other Miscellaneous	0	0	0	4	2	6	6
	6	10	16	25	18	43	59

Exhibit
#13

LEGAL SERVICES OF ARKANSAS, INC.
1990* STAFF - 60+
*January - May, 1990

	BLACK			WHITE			
	F	M	T	F	M	T	GT
Type Problem							
Bankruptcy/Debtor Relief	0	1	1	1	1	2	3
Collect/Repo/Defic/Garn.	1	1	2	3	0	3	5
Contracts	1	0	1	1	1	2	3
Divorce	0	0	0	1	0	1	1
Other Family	1	0	1	0	0	0	1
Medicaid	2	0	2	2	1	3	5
Fed. Sub. Housing Rights	0	0	0	1	0	1	1
Homownership/Real Prop.	2	0	2	2	2	4	6
Landlord/Tenant	1	0	1	0	0	0	1
Food Stamps	1	1	2	2	0	2	4
Social Security	0	1	1	0	0	0	1
SSI/SSD	2	2	4	7	1	8	12
Veterans Benefits	0	0	0	1	0	1	1
Other Income Maintenance	1	0	1	0	0	0	1
Other Individual Rights	0	0	0	2	0	2	2
Torts	0	1	1	1	0	1	2
Wills/Estates	0	1	1	1	0	1	2
Other Miscellaneous	1	1	2	1	0	1	3
	13	9	22	26	6	32	54

Exhibit
#14

LEGAL SERVICES OF ARKANSAS, INC.
1990* AVLE - 60+
*January - May, 1990

	BLACK			WHITE			
	F	M	T	F	M	T	GT
Type Problem							
Bankruptcy/Debtor Relief	0	0	0	2	1	3	3
Collect/Repo/Defic/Garn.	0	0	0	2	0	2	2
Contracts	0	0	0	1	0	1	1
Other Consumer/Finance	0	0	0	1	1	2	2
Adoption	0	0	0	0	1	1	1
Divorce	1	1	2	4	3	7	9
Guardianship/Conserv.	1	0	1	2	0	2	3
Homownership/Real Prop.	2	1	3	5	2	7	10
Wills/Estates	1	1	2	5	2	7	9
Other Miscellaneous	1	0	1	0	0	0	1
	6	3	9	22	10	32	41

Exhibit
#15

LEGAL SERVICES OF ARKANSAS, INC.
1990* REJECTIONS, STAFF AND AVLE BY COUNTY - 60+
*January - May, 1990

	REJECTIONS	STAFF	AVLE	GTOTAL
County				
Arkansas	2	3	1	6
Ashley	5	6	0	11
Bradley	0	3	2	5
Calhoun	1	1	0	2
Chicot	2	2	0	4
Cleveland	3	1	2	6
Columbia	0	0	3	3
Conway	3	1	1	5
Dallas	3	2	0	5
Desha	4	7	0	11
Drew	3	1	1	5
Grant	1	0	2	3
Howard	0	1	2	3
Lincoln	1	1	1	3
Montgomery	1	1	3	5
Nevada	4	2	0	6
Ouachita	3	1	3	7
Perry	2	0	1	3
Pike	0	0	0	0
Polk	5	8	4	17
Prairie	3	1	1	5
Sevier	0	2	1	3
Union	10	7	7	24
White	3	3	6	12
Totals	59	54	41	154

Exhibit
#16

MAJOR REASON CASE CLOSED

CODE	REASON
A	Counsel and Advice
B	Brief Service (other than Counsel and Advice)
C	Referred After Legal Assessment
D	Insufficient Merit to Proceed
E	Client Withdrew or Did Not Return
F	Negotiated Settlement Without Litigation
G	Negotiated Settlement With Litigation
H	Administrative Agency Decision
I	Court Decision
J	Change Eligibility Status
K	Other

```
                              CASE STATISTICAL REPORT

   604051-5        89D
   LEGAL SERVICES OF ARKANSAS
   Private Attorney Involvement
   Prepared by:  Sarita Taylor
   Report for period ending:   12/31/89
                                   REASON CLOSED                  Page     1
   RACE        YOUNGER THAN 18   18 THRU 60     OLDER THAN 60     TOTAL


=============================================================================
BLACK                  0              8              6              14
=============================================================================
WHITE                  1             24             16              41

                 THE GRAND TOTAL OF CLOSED CASES

THE TOTALS             1             32             22              55
```

CASE STATISTICAL REPORT

604051-5 89D
LEGAL SERVICES OF ARKANSAS
Private Attorney Involvement
Prepared by: Sarita J. Taylor
Report for period ending: 12-31-89

Page 1

	REASON CLOSED											
PCODE SUBJECT	A	B	C	D	E	F	G	H	I	J	K	TOTAL
30ADOPTIONS	0	1	0	0	0	0	0	0	1	0	0	2
31CUSTODY VIS	0	1	0	0	1	0	0	0	1	0	0	3
32DIV SEP ANN	0	0	0	0	11	0	0	0	16	0	0	27
33GUARDIANSH.	1	0	0	1	1	0	0	0	1	0	0	4
36PATERNITY	0	0	0	0	0	0	0	0	2	0	0	2
37SPOUSE ABUS	0	0	0	0	0	0	0	0	1	0	0	1
38SUPPORT	0	0	0	0	1	0	0	0	0	0	0	1
SUB TOTAL	1	2	0	1	14	0	0	0	22	0	0	40
59 O. HEALTH	0	0	0	0	1	0	0	0	0	0	0	1
SUB TOTAL	0	0	0	0	1	0	0	0	0	0	0	1
62HOME/REAL P	1	1	0	0	0	1	0	0	0	0	0	3
69OTHER HOUSE	0	0	0	0	0	0	0	0	0	0	1	1
SUB TOTAL	1	1	0	0	0	1	0	0	0	0	1	4
93LICENSE	0	1	0	0	0	0	0	0	0	0	0	1
95WILLS ESTAT	1	3	0	0	1	0	0	0	1	0	1	7
99OTHER MISC	1	1	0	0	0	0	0	0	0	0	0	2
SUB TOTAL	2	5	0	0	1	0	0	0	1	0	1	10
THE GRAND TOTAL OF CLOSED CASES												
The totals	4	8	0	1	16	1	0	0	23	0	2	55

Exhibit
#17

CASE STATISTICAL REPORT

604051-0 89D
LEGAL SERVICES OF ARKANSAS
Basic Field
Prepared by: Sarita J. Taylor
Report for period ending: 12-31-89

REASON CLOSED Page 1

RACE	YOUNGER THAN 18	18 THRU 60	OLDER THAN 60	TOTAL
BLACK	2	134	20	156
HISPANIC	0	1	0	1
NATIVE AMERICAN	0	2	0	2
WHITE	5	297	45	347

THE GRAND TOTAL OF CLOSED CASES

THE TOTALS	7	434	65	506

CASE STATISTICAL REPORT

604051-0 89D
LEGAL SERVICES OF ARKANSAS
Basic Field
Prepared by: Sarita J. Taylor
Report for period ending: 12-31-89

REASON CLOSED Page 1

PCODE SUBJECT	A	B	C	D	E	F	G	H	I	J	K	TOTAL
1BANKRUPTIES	7	1	0	0	2	0	0	0	5	0	0	15
2COLLECTIONS	23	6	2	1	1	1	0	0	4	0	0	38
3CONTRACTS	5	2	2	0	1	0	0	0	0	0	0	10
4CREDIT ACC.	2	0	0	0	0	0	0	0	0	0	0	2
6LOANS	1	0	0	0	0	0	0	0	0	0	0	1
7PUB UTILITY	1	0	0	0	0	0	0	0	0	0	0	1
8UNFAIR SALE	0	0	1	0	0	0	0	0	0	0	0	1
9OTHER CONS.	1	0	0	0	0	0	0	0	0	0	0	1
SUB TOTAL	40	9	5	1	4	1	0	0	9	0	0	69
11EDUCATION	1	0	0	0	0	0	0	0	0	0	0	1
SUB TOTAL	1	0	0	0	0	0	0	0	0	0	0	1
21JOB DISCRIM	2	0	0	0	0	0	0	0	0	0	0	2
22WAGE CLAIMS	0	0	0	0	0	0	1	0	0	0	0	1

CASE STATISTICAL REPORT

604051-0 89D
LEGAL SERVICES OF ARKANSAS
Basic Field
Prepared by: Sarita J. Taylor
Report for period ending: 12-31-89

PCODE SUBJECT	REASON CLOSED A	B	C	D	E	F	G	H	I	J	K	TOTAL
29OTHER EMPLOY	5	0	0	0	0	0	0	0	0	0	0	5
SUB TOTAL	7	0	0	0	0	0	1	0	0	0	0	8
30ADOPTIONS	1	4	1	1	2	0	0	0	6	0	0	15
31CUSTODY VIS	17	1	5	0	3	0	0	0	8	0	0	34
32DIV SEP ANN	18	3	14	0	27	0	1	0	73	1	2	139
33GUARDIANSH.	7	4	0	1	1	0	0	0	3	1	0	17
34NAME CHANGE	0	0	0	0	1	0	0	0	0	0	0	1
36PATERNITY	3	1	0	0	2	0	0	0	4	0	0	10
37SPOUSE ABUS	1	0	0	0	0	0	0	0	1	0	0	2
38SUPPORT	18	5	3	0	4	0	0	0	6	0	0	36
39OTHER FAMIL	6	1	0	1	0	1	0	0	0	0	0	9
SUB TOTAL	71	19	23	3	40	1	1	0	101	2	2	263
42NEG/ABS CHIL	0	0	1	0	1	0	0	0	1	0	1	4
SUB TOTAL	0	0	1	0	1	0	0	0	1	0	1	4
51MEDICAID	3	1	0	0	0	0	0	1	0	0	0	5
59 O. HEALTH	1	2	0	0	1	0	0	0	0	0	0	4
SUB TOTAL	4	3	0	0	1	0	0	1	0	0	0	9
61FED SUB HOU	4	1	0	2	1	2	0	0	3	0	0	13
62HOME/REAL P	5	3	1	0	1	1	0	0	2	0	0	13
63L/TENANT	3	1	0	0	0	0	0	0	1	0	0	5
64OTHER P HOU	1	1	0	0	0	0	0	0	0	0	0	2
69OTHER HOUSE	4	1	0	0	0	0	0	0	0	0	1	6
SUB TOTAL	17	7	1	2	2	3	0	0	6	0	1	39

CASE STATISTICAL REPORT

604051-0 89D
LEGAL SERVICES OF ARKANSAS
Basic Field
Prepared by: Sarita J. Taylor
Report for period ending: 12-31-89

Page 4

PCODE SUBJECT					REASON CLOSED							
	A	B	C	D	E	F	G	H	I	J	K	TOTAL
71AFDC	4	1	0	0	0	2	0	1	0	0	0	8
73FOOD STAMPS	4	3	0	0	2	1	0	0	0	0	0	10
74SOCIAL SEC.	3	1	0	0	1	0	0	0	0	0	0	5
75SSI	16	5	1	2	1	1	0	13	1	1	0	41
76UNEMPLOYMENT	1	1	0	0	0	0	0	3	0	0	0	5
77VETERAN BEN	1	1	0	0	0	0	0	0	0	0	0	2
78WORKERS COMP	2	0	0	0	0	0	0	0	0	0	0	2
79O. INC. MAN	2	1	0	0	0	0	0	0	0	0	0	3
SUB TOTAL	33	13	1	2	4	4	0	17	1	1	0	76
89OTHER IND RG	1	0	0	0	0	0	0	0	0	0	0	1
SUB TOTAL	1	0	0	0	0	0	0	0	0	0	0	1
93LICENSE	1	2	0	0	0	0	0	0	1	0	0	4
94TORTS	9	0	0	0	0	0	0	0	0	0	0	9
95WILLS ESTAT	4	8	0	0	1	0	0	0	2	0	1	16
99OTHER MISC	3	3	0	0	1	0	0	0	0	0	0	7
SUB TOTAL	17	13	0	0	2	0	0	0	3	0	1	36
THE GRAND TOTAL OF CLOSED CASES												
The totals	191	64	31	8	54	9	2	18	121	3	5	506

Exhibit

#18

CASE STATISTICAL REPORT

604051-5-A 90 A
LEGAL SERVICES OF ARKANSAS, INC.
Private Attorney Involvement
Prepared by: Sarita Taylor
Report for period ending: 03-31-90

REASON CLOSED

Page 1

RACE	YOUNGER THAN 18	18 THRU 60	OLDER THAN 60	TOTAL
BLACK	1	20	5	26
NATIVE AMERI	0	2	0	2
WHITE	1	58	11	70

THE GRAND TOTAL OF CLOSED CASES

THE TOTALS	2	80	16	98

CASE STATISTICAL REPORT

604051-5-A 90 A
LEGAL SERVICES OF ARKANSAS, INC.
Private Attorney Involvement
Prepared by: Sarita Taylor
Report for period ending: 03-31-90

REASON CLOSED

Page 1

PCODE SUBJECT	A	B	C	D	E	F	G	H	I	J	K	TOTAL
2COLLECTIONS	1	0	0	0	1	0	0	0	0	0	2	4
3CONTRACTS	0	1	0	0	0	0	0	0	0	0	0	1
SUB TOTAL	1	1	0	0	1	0	0	0	0	0	2	5
30ADOPTIONS	0	0	0	0	3	0	0	0	1	0	0	4
31CUSTODY VIS	0	0	0	0	1	0	0	0	2	0	1	4
32DIV SEP ANN	0	0	0	0	31	2	0	0	33	0	1	67
33GUARDIANSH	0	0	0	0	1	0	0	0	1	0	0	2
34NAME CHANGE	0	0	0	0	1	0	0	0	0	0	0	1
36PATERNITY	0	0	0	0	1	0	0	0	0	0	0	1
SUB TOTAL	0	0	0	0	38	2	0	0	37	0	2	79
42NEG/ABS CHIL	0	0	0	0	0	0	0	0	1	0	0	1
SUB TOTAL	0	0	0	0	0	0	0	0	1	0	0	1

CASE STATISTICAL REPORT

604051-5-A 90 A
LEGAL SERVICES OF ARKANSAS, INC.
Private Attorney Involvement
Prepared by: Sarita Taylor
Report for period ending: 03-31-90

REASON CLOSED Page 2

PCODE SUBJECT	A	B	C	D	E	F	G	H	I	J	K	TOTAL
51MEDICAID	0	1	0	0	0	0	0	0	0	0	0	1
SUB TOTAL	0	1	0	0	0	0	0	0	0	0	0	1
62HOME/REAL P	0	2	0	0	1	0	0	0	1	0	0	4
63L/TENANT	0	0	0	0	1	0	0	0	0	0	0	1
SUB TOTAL	0	2	0	0	2	0	0	0	1	0	0	5
95WILLS ESTAT	0	2	0	0	1	0	0	0	0	0	1	4
99OTHER MISC	0	0	0	0	1	0	0	0	1	0	1	3
SUB TOTAL	0	2	0	0	2	0	0	0	1	0	2	7

THE GRAND TOTAL OF CLOSED CASES

	A	B	C	D	E	F	G	H	I	J	K	TOTAL
The totals	1	6	0	0	43	2	0	0	40	0	6	98

Exhibit
19

CASE STATISTICAL REPORT

604051-0-A 90 A
LEGAL SERVICES OF ARKANSAS, INC.
Basic Field
Prepared by: Sarita J. Taylor
Report for period ending: 03-31-90

REASON CLOSED
Page 1

RACE	YOUNGER THAN 18	18 THRU 60	OLDER THAN 60	TOTAL
ASIAN OR PAC	0	1	0	1
BLACK	2	172	23	197
HISPANIC	0	2	0	2
NATIVE AMERI	0	2	0	2
WHITE	3	278	22	303

THE GRAND TOTAL OF CLOSED CASES

THE TOTALS	5	455	45	505

CASE STATISTICAL REPORT

604051-0-A 90 A
LEGAL SERVICES OF ARKANSAS, INC.
Basic Field
Prepared by: Sarita Taylor
Report for period ending: 03-31-90

REASON CLOSED
Page 1

PCODE SUBJECT	A	B	C	D	E	F	G	H	I	J	K	TOTAL
1BANKRUPTIES	14	1	0	0	0	0	0	0	2	0	0	17
2COLLECTIONS	24	1	2	0	1	2	0	0	10	0	2	42
3CONTRACTS	3	2	0	0	0	0	0	0	1	0	0	6
6LOANS	1	0	0	0	0	0	0	0	0	0	0	1
7PUB UTILITY	2	0	0	0	0	0	0	0	0	0	0	2
9OTHER CONS.	1	0	0	0	1	0	0	0	0	0	0	2
SUB TOTAL	45	4	2	0	2	2	0	0	13	0	2	70
11EDUCATION	3	3	0	0	1	0	0	0	0	0	0	7
SUB TOTAL	3	3	0	0	1	0	0	0	0	0	0	7
21JOB DISCRIM	3	0	0	0	0	0	0	0	0	0	0	3
29OTHER EMPLOY	6	1	0	0	0	0	0	0	1	0	0	8
SUB TOTAL	9	1	0	0	0	0	0	0	1	0	0	11

CASE STATISTICAL REPORT

604051-0-A 90 A
LEGAL SERVICES OF ARKANSAS, INC.
Basic Field
Prepared by: Sarita Taylor
Report for period ending: 03-31-90

Page 2

PCODE SUBJECT	A	B	C	D	REASON CLOSED E	F	G	H	I	J	K	TOTAL
30ADOPTIONS	0	1	0	0	4	0	0	0	5	0	0	10
31CUSTODY VIS	12	4	2	0	3	0	1	0	8	0	2	32
32DIV SEP ANN	12	0	4	0	47	2	0	0	72	0	1	138
33GUARDIANSH.	4	2	0	0	4	0	0	0	3	0	0	13
34NAME CHANGE	1	1	0	0	1	0	0	0	0	0	0	3
35PARENTAL R.	0	0	0	0	0	0	0	0	2	0	0	2
36PATERNITY	5	0	0	0	1	0	0	0	2	0	0	8
38SUPPORT	23	6	1	0	0	1	0	0	2	0	0	33
39OTHER FAMIL	5	0	1	0	0	0	0	0	0	0	0	6
SUB TOTAL	62	14	8	0	60	3	1	0	94	0	3	245
42NEG/ABS CHIL	2	1	0	0	0	0	0	0	2	0	0	5
49OTHER JUVEN	1	0	0	0	0	0	0	0	0	0	0	1
SUB TOTAL	3	1	0	0	0	0	0	0	2	0	0	6
51MEDICAID	4	3	0	0	0	0	0	3	0	0	0	10
59 O. HEALTH	1	0	0	0	0	0	0	0	0	0	0	1
SUB TOTAL	5	3	0	0	0	0	0	3	0	0	0	11
61FED SUB HOU	9	8	0	0	0	0	1	0	3	0	0	21
62HOME/REAL P	2	4	0	0	3	1	0	0	3	0	0	13
63L/TENANT	7	0	0	0	1	0	0	0	0	0	0	8
64OTHER P HOU	1	0	0	0	0	0	0	0	0	0	0	1
69OTHER HOUSE	5	0	0	0	0	0	0	0	0	0	0	5
SUB TOTAL	24	12	0	0	4	1	1	0	6	0	0	48

CASE STATISTICAL REPORT

604051-0-A 90 A
LEGAL SERVICES OF ARKANSAS, INC.
Basic Field
Prepared by: Sarita Taylor
Report for period ending: 03-31-90

REASON CLOSED Page 4

PCODE SUBJECT	A	B	C	D	E	F	G	H	I	J	K	TOTAL
71AFDC	4	4	0	0	0	0	0	1	0	0	0	9
73FOOD STAMPS	3	1	0	0	0	1	0	0	0	0	0	5
74SOCIAL SEC.	1	1	0	0	0	0	0	0	0	0	0	2
75SSI	14	6	2	4	1	0	0	19	1	0	1	48
76UNEMPLOYMENT	1	0	0	0	0	0	0	1	1	0	0	3
77VETERAN BEN	1	0	0	0	0	0	0	0	0	0	0	1
79O. INC. MAN	2	1	0	0	0	0	0	0	0	0	0	3
SUB TOTAL	26	13	2	4	1	1	0	21	2	0	1	71
89OTHER IND RG	1	0	0	0	0	0	0	0	0	0	0	1
SUB TOTAL	1	0	0	0	0	0	0	0	0	0	0	1
93LICENSE	0	1	0	0	1	0	0	0	0	0	0	2
94TORTS	11	3	0	0	0	0	0	0	2	0	0	16
95WILLS ESTAT	2	2	0	0	2	0	0	0	2	0	1	9
99OTHER MISC.	4	1	0	0	1	0	0	0	1	0	1	8
SUB TOTAL	17	7	0	0	4	0	0	0	5	0	2	35

THE GRAND TOTAL OF CLOSED CASES

	A	B	C	D	E	F	G	H	I	J	K	TOTAL
The totals	195	58	12	4	72	7	2	24	123	0	8	505

Ms. O'SHAUGHNESSY. Thank you, David. You certainly raise some interesting issues. Waivers, means testing, role of volunteers.

Our next speaker is Arnie Whedbee, who is the Coordinator of Litigation, Advocacy and Training for Evergreen Legal Services in Seattle. Prior to that, Mr. Whedbee has had wide experience in senior legal services programs, including a prior position as a vista attorney in Washington State. He has very wide experience in Medicaid eligibility policy and ombudsman programs as well as legal services. He's going to talk to us from the perspective of a legal services corporation/area agency grantee.

STATEMENT OF ARNIE WHEDBEE, COORDINATOR OF LITIGATION, ADVOCACY AND TRAINING, EVERGREEN LEGAL SERVICES, SEATTLE, WA

Mr. WHEDBEE. Thank you. I appreciate the opportunity of Senator Pryor and Senator Heinz to be here today. My name is Arnie Whedbee. I am an attorney with Evergreen Legal Services in Washington State, and I'd like to talk about two broad areas.

One is the legal services or legal assistance network, the III(b) network in Washington State, and some of the barriers that I think we've experienced over the last couple of years and tried to address, and I'd also like to talk a little bit about some of the developments in terms of the ombudsman program in Washington State and some of my ideas on linking up legal services III(b) programs with ombudsman programs.

We started out providing legal services to the elderly about 1975 or 1976, basically because the director of the aging agency in our State provided model project money so that when those services became a priority under the Act there was some precedent and there was some work that had already been done and I think very quickly all of the AAAs in the State funded legal services.

That delivery system has evolved over the last 15 years, and it's quite varied at this point in time. There are two legal services corporation funded grantees that account for probably about eight of the AAAs in the State. There's a Gonzaga University Law School that operates a clinical program using law students and supervising attorneys.

There's a private law firm that has one of the AAA contracts. We also spend our private bar money with that particular law firm. There's a private bar panel that we run to extremely rural parts of the State, many, many counties, hundreds of square miles, where during the cutbacks that we as a legal services program experienced in 1982, 1983, and 1984 where we laid off 65 staff and closed seven offices. We kept those AAA contracts, and we administer those AAA contracts through a panel of private attorneys. That doesn't work as well as some of the staff model programs, in my opinion, but I think it's better than nothing.

We don't do wills, we don't do windows, either. What, though, I think, primarily that system does is four basic areas, and that is basic survival issues for the elderly: adequate income, health care, housing, utilities, food. So those are the types of legal problems that we work on.

There are parts of the system that do wills, there are parts of the system that use lay advocates, there are parts of the system that have call-ins and brief telephone advice and pamphlets sent to your door describing various legal rights, but I think the bulk of the III(b) money goes for basic survival.

Even though this system is, in some respects, 15 years old, we, at least I personally, gained some real insight about 2 years ago when Penny Hommel and her staff visited our State, and for the first time in that 15-year period we spent 2 days with legal services people from Oregon, Hawaii, and I think there might have been one other State in there, and AAA people all in the same room for 2 days.

It was the first time that I had ever dealt with them, other than in contract negotiation or on some advocacy projects or some issues, and it was very helpful and it was very insightful for me. There was a role play where we got to be the AAAs and they got to be the legal services people, and we could be mean and nasty and require all kinds of records and reports, and they could withhold client names from us and not really tell us why.

But as a result of that, we've made some changes over the last 2 years, and I've outlined them in the material. One is that we are having quarterly meetings with all these legal services providers, the law school, the private attorney, the various parts of it, where we get together and talk about issues, talk about cases, talk about strategy, talk about common approaches to problems.

We had Penny come back to our State with Bill Benson about a year ago, and we sat down again with AAA providers, three of them, a director, a staff person, and so forth, and these three various components of the III(b) system, and we hammered at standards for legal services.

What is it? What kind of cases should they do? What are the priorities? What are the linkages between the ombudsman program? What are the linkages between case management? What types of reports are reasonable to be provided by legal services? What kind of reports will help AAAs in their planning and advocacy activities and so forth? Again, I think we have a good framework, and I think that removed some barriers.

The third thing that we did, and I've done some attachments, we started sending out—and I'm sure a lot of people do this locally maybe, but we starting doing it on a statewide basis—and that is sending senior bulletins quite frequently, and we invited various people to have comments on that. Those are Medicaid changes, changes in the Copes Program, changes in VA benefits, what have you.

Some of them are more sophisticated, others are in the form of announcements, and we send that to about 300 people, and we are constantly increasing that audience, and that audience consists of long-term care facilities, private attorneys, case managers, and, of course, all of the Title III(b) providers. I think that really helps define what you're working on. I think it helps get a lot of people to work on the same issues when that's appropriate and possible because these issues, many times, are very complex.

We also started hanging out much more with constituency groups than I think we had over the previous 5 or 10 years, and one group is the senior lobby in Washington State, and it has been in existence for probably 10 to 12 years, and it represents 22 organizations in the State of Washington—the Gray Panthers, AARP, retired union people, retired teachers, retired Government employees, and so forth—and we found that we had a lot in common.

Some of the issues that they were concerned about we weren't even aware of. I'll give you an example in the income area. We do work in terms of SSI, termination of benefits in SSI, overpayments in SSI and so forth, but another aspect of that income problem that they had picked up on is that from 1979 to 1989, while the COLAs were increasing at the Federal level, our State supplement payment was decreasing, so our SSI payment in Washington State went from 89 percent of the poverty level in 1979 to 79 percent of the poverty level.

That's something that they're concerned about working on, and they have sought our legal analysis in a number of areas like that. One of the most recent is in the whole guardianship area. They worked for 2 years to pass an extremely comprehensive guardianship reform bill, and at the same time one of our staff attorneys in Seattle was on a task force that the Bar Association was sponsoring that also monitored that piece of legislation and provided comments to the legislation, and they've given us a couple of other challenges.

They want to look at the elderly in the homeless population and what can be done about that, they are very concerned about discrimination in the mental health system in our State. So I think not only have some of those steps helped break down some barriers, but I think the advocacy has vastly improved.

And I think also, in terms of funding sources, I heard earlier that sometimes your activities may cause your funding sources to frown on that and so forth, but I think if you have an organization like the senior lobby that represents a significant number of people in Washington State, and that's their issue also, then you're in good company, and I think that has helped out.

In terms of linkages in terms of legal services and long-term care ombudsman programs, there are a couple of developments that I've outlined in the material that our legislature has done over the last 2 years. One is to place the agency in a new State government agency and require that it be contracted out to a nonprofit organization. That took place last year.

The second thing that occurred is that in this last legislative session there was actually an amount, $75,000, earmarked solely to ensure adequate legal assistance to both residents of long-term care facilities and staff of the program, which I think is a first in the country, and we're real excited about it.

The second thing that occurred during this period is that the ombudsman budget went from about $200,000 a biennium to about $660,000 a biennium, and I think the reason for that was because senior groups, resident councils, and so forth, for the first time, had a cause and had something to work toward in terms of having a piece of that ombudsman program and advocating for adequate funding. I don't think we're there yet in terms of adequate funding, but we're a lot further along.

It's interesting. I heard some of the Title III statistics this morning. Our basic grant is basically only about 14 percent Title III, and the rest is State dollars, so there's really not that much in terms of Title III support.

We met with the ombudsman recently hired 3 or 4 months ago, and I think he's going to be very good. When we described this III (b) legal services, the law school and the clinics and the legal services offices, his eyes lit up. The next question was, what are the phone numbers of all of these places so that I can refer cases to you? We said time out. We don't want 5,000 phone calls tomorrow, we don't want 5,000 Medicaid eligibility cases, either.

It seems to us that it's your responsibility to figure out what the problems are in long-term care facilities in this State, it's your problem to work on those to the extent of your system and determine situations in which you need an attorney and you're not able to pursue that by referring it to a regulatory agency or by doing it yourself or utilizing your volunteers or however you're going to develop your program, and then, you know, we would be more than happy to sit down with you and talk about those types of cases.

We also said we'd do some training, pick a subject, and, of course, we got sucked into that, and we went to the training, and immediately, you know, we found a great case, and the case is Lady A runs an ad in the paper advertising services, people call in, she has rented a house, she tells them about Lady B, Lady B does a contract for about $1,200 or $1,300 a month, Lady A does a contract for $600 a month to provide services, and we put five or six or seven elderly folks in this place, and the team makes $10,000 or $12,000 a month.

So this case caught our attention, so even though we're not into formal priorities and so forth, we are working on this. What was interesting is that there was a court case that the ombudsman program got hold of in which the Attorney General tried to shut the place down and lost, and so this particular arrangement has survived the test of our State's adult family home laws and our State's boarding home laws, which suggests some possibly legislative solutions.

Those couldn't occur until next January, though, so we're hoping that something could be done about this. It's interesting also in the court case that about a year ago they revoked this individual's license because of a fire in a home that had seven residents instead of the required four, and three people died, so basically what they've done is they've simply continued to operate and are operating right now as we speak.

We've also taken a couple of guardianship cases where people have been placed against their will, either under a durable power of attorney or a guardianship placed in residential settings, which our State law provides that even if you have a guardian, you have to go through the mental commitment proceeding, and you cannot place someone in a nursing home or a residential treatment setting against their will.

So we're really looking forward to working with this new ombudsman program, and I want to close with some remarks, a quote.

> Our Nation has been conducting investigations, passing new laws, and issuing new regulations relative to nursing homes at a rapid rate during the past few years.

> All of this activity will be of little avail unless our communities are organized in such a manner that new laws and regulations are utilized to deal with the individual complaints of older people who are living in nursing homes. The individual in the nursing home is powerless. If the laws are not applied to them, they might just as well have not been passed or issued at all.

Some of you are probably familiar with that statement, but it was Arthur Fleming in the first AOA program explanation for the ombudsman program, and it was issued in 1975. So from what I heard this morning and from us starting back at square one, after 15 years, there's still a little ways to go. Thanks for your time.

[The prepared statement of Arnie Whedbee follows:]

TESTIMONY OF ARNIE WHEDBEE ON
REAUTHORIZATION OF THE OLDER AMERICANS ACT

III-B Legal Services Network in Washington State

1 - Legal Services Corporation Programs

- Evergreen Legal Services
- Puget Sound Legal Assistance Foundation

2 - Gonzaga University Law School - Clinical Program

3 - Tracy - Private Law Firm

4 - Private Bar Panel

5 - Senior Legal Advice Clinic

Coordination

- Quarterly meetings of all III-B providers
- Joint development of Standards for Legal Assistance
- Statewide distribution of the SENIOR BULLETIN to III-B providers, AAA's, Senior Advocates, Long Term Care Facilities and Private Attorneys

III-B Legal Services Providers - Linkage with Long-Term Care Ombudsman Program

1 - Priority Setting - Long-Term Care residents must be involved in local legal services priority setting process. They must also be involved in the Area Agency on Aging Planning and Resource allocation process.

2 - Standards - Standards for Legal Services providers should include the capacity to deliver services to the elderly in residential settings. Each III-B provider should have a cooperative agreement with the Ombudsman Program that spells out mutual referral and direct service obligations.

Long-Term Care Ombudsman - Washington State Law Developments

1 - 1989 - Ombudsman Program contract to private nonprofit based upon legislative directive:

> **The department of community development shall contract with a private nonprofit organization to provide long-term care ombudsman services as specified under, and consistent with, the federal older Americans act as amended, federal mandates, the goals of the state, and the needs of its citizens.**

2 - 1990 - State funding for Legal Assistance to Residents of Long-Term Care Facilities:

> **$375,000 of the general fund--state appropriation is provided solely to enhance the long-term care ombudsman program. Of this amount: (a) $75,000 is provided solely to ensure adequate legal assistance to both residents of long-term care facilities and staff of the program; and (b) $100,000 is provided solely to establish at least two additional service sites.**

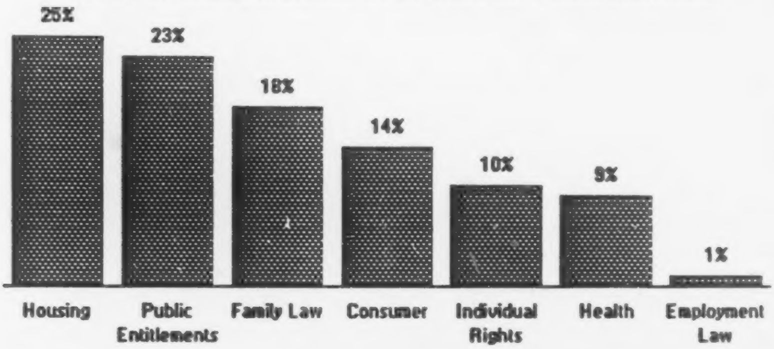
EVERGREEN LEGAL SERVICES

- In the Service of Justice

Evergreen Legal Services is the largest of three publicly-funded civil legal services programs in Washington, serving a year-round poverty population of approximately 447,424 in 31 counties which extend over a 53,609 square mile area. In addition, Evergreen serves an estimated 100,000 migrant workers, a substantial Native American community, and some institutionalized poor persons in the state. (The other two programs are Puget Sound Legal Assistance Foundation which serves Pierce and Thurston counties and Spokane Legal Services Center which serves Spokane, Ferry, Lincoln, Stevens, and Pend Oreille counties.)

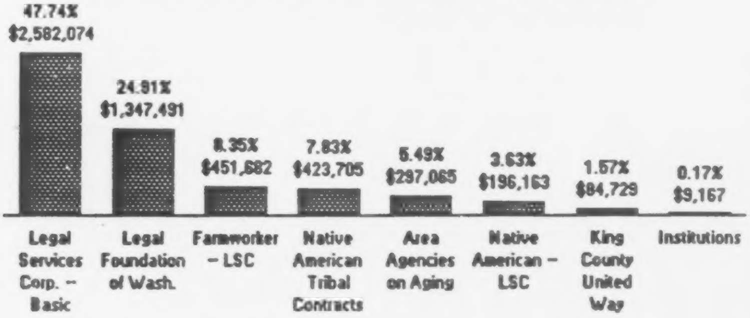
Evergreen provides a full range of legal services, from advice, referral, investigation and research to formal representation before courts and administrative bodies, legislative advocacy and public education.

TYPES OF CASES HANDLED BY EVERGREEN LEGAL SERVICES



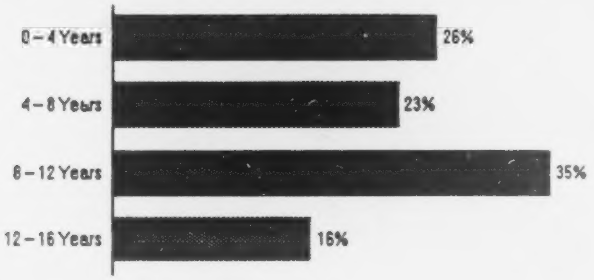
In 1981, severe reductions in federal Legal Services Corporation (LSC) funding resulted in the layoff of 65 attorneys and the closure of 7 offices. Since then, LSC funding has remained static despite increased demand for services and steadily increasing costs.

EVERGREEN LEGAL SERVICES FUNDING SOURCES



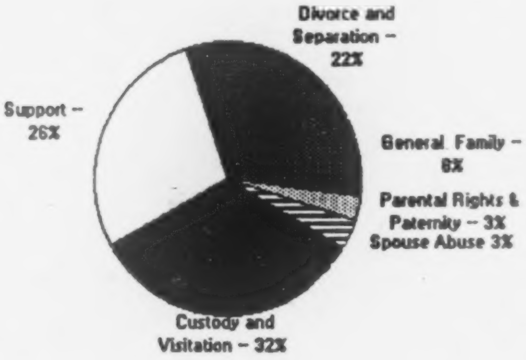
Evergreen employs an experienced staff of 115 people, including attorneys, paralegals and support staff, and annually serves an estimated 25,000 poor persons eligible for legal services residing within its service area.

EXPERIENCE LEVELS OF EVERGREEN ATTORNEYS



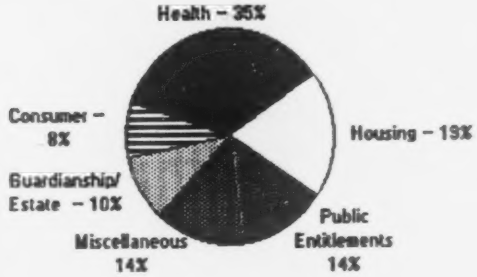
In addition to eight general field offices, Evergreen supports several special projects. Family Law specialists handle a wide variety of family law cases.

EVERGREEN FAMILY LAW CASE TYPES



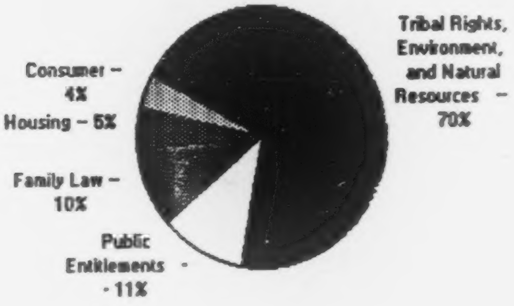
Older Americans Act funding is used to represent those senior citizens who are in the greatest social and economic need.

EVERGREEN SENIOR SERVICES CASE TYPES



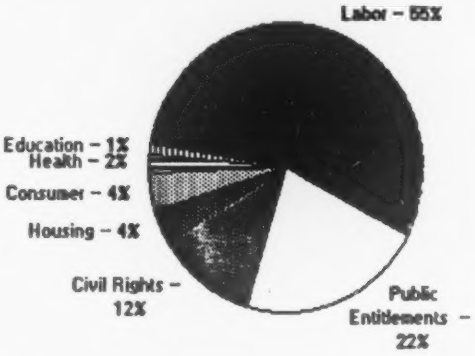
The Native American Project serves low-income Native Americans and eligible tribes.

EVERGREEN NATIVE AMERICAN PROJECT CASE TYPES



The Farmworker Division protects the rights of migrant workers.

EVERGREEN FARMWORKER DIVISION CASE TYPES

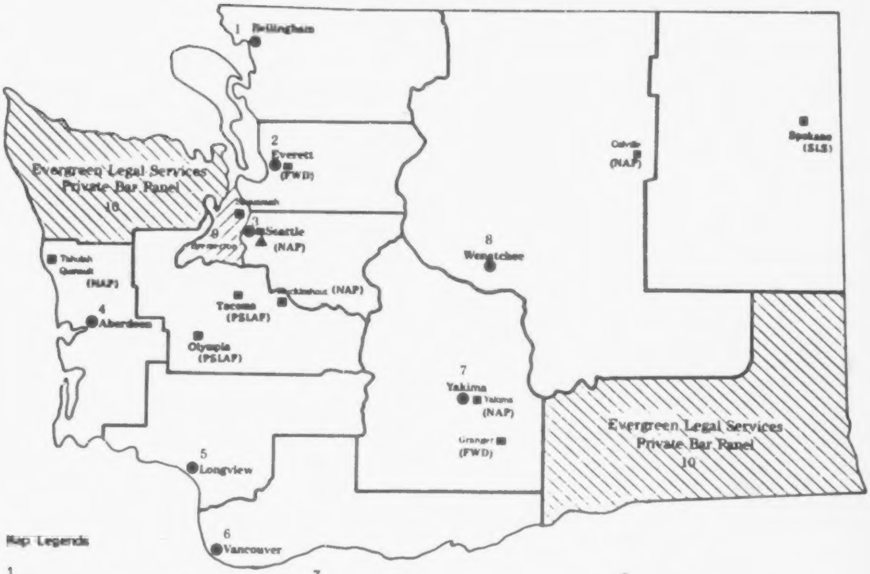


The Institutional Legal Services Project represents low-income persons in various juvenile, correctional, and mental health facilities.

Evergreen has developed private bar involvement programs which have received national recognition, such as a compensated private bar panel in Southeastern Washington, Clallam and Jefferson Counties, a private law firm contract to represent low-income persons in Kitsap County, and pro bono referral projects in Seattle-King County, Chelan-Douglas and Yakima Counties.

At the state and local levels, Evergreen attorneys have also represented the poor by serving on such advisory or policy-making bodies as the Washington State Hospital Commission, Governor's Committee on Disability Issues and Employment, Governor's Task Force on Child Support, Sentencing Guidelines Commission and the Governor's Task Force on Community Protection, all by gubernatorial appointment. Staff members have also served on the Washington State Supreme Court's Interpreter Task Force, the Department of Social and Health Services Commission on Financial Responsibility and its Income Assistance Advisory Committee, the Washington State Juvenile Disposition Standards Committee, and a wide variety of committees and task forces addressing the problems of migrant workers, the unemployed, victims of domestic violence, and the elderly. In addition, Evergreen staff play an active role in state and local bar association activities and committees.

Area Map


1 Bellingham
2 Everett
(FWD)
Evergreen Legal Services
Private Bar Panel
10
Suquamish
3 Seattle
(NAP)
9
Bremerton
Taholah
Quinault
(NAP)
Muckleshoot (NAP)
Tacoma
(PSLAF)
4 Aberdeen
Olympia
(PSLAF)
8
Wenatchee
Colville
(NAP)
Spokane
(SLS)
7
Yakima
Yakima
(NAP)
Granger
(FWD)
Evergreen Legal Services
Private Bar Panel
10
5 Longview
6 Vancouver

Map Legends

1
Evergreen Legal Services
Northwest Regional Office,
Skagit, Whatcom, San Juan &
Island Counties
Bellingham, WA
1 800 562-8836
206 734-8680

2
Snohomish County Office,
Everett, WA
1 800 822-0225
206 259-3421

3
King County Office,
Seattle, WA
206 464-1422

4
Grays Harbor-Pacific
Counties Office,
Aberdeen, WA
1 800 634-9909
206 532-3501

5
Lewis, Cowlitz & Wahkiakum
Counties Office,
1 800 562-1714
206 423-7300

6
Clark, Klickitat &
Skamania Counties Office,
Vancouver, WA
1 800 331-3533
206 693-2941

7
Yakima-Kittitas
Counties Office,
Yakima, WA
1 800 631-1323
509 575-5593

8
North Central Regional Office,
Chelan, Douglas, Okanogan,
Grant & Adams Counties
Wenatchee, WA
1 800 572-9615
509 662-9681

Senior Citizens
-Special Senior Citizens
Law Services funded by the
Area Agencies on Aging
are located in Offices 1-8

9
Private Bar Contract
Kitsap County
Bremerton, WA
206 479-6644

10
Private Bar Panel
Serving:
Clallam & Jefferson Counties
Southeast Washington: Columbia
Garfield, Walla Walla, Asotin,
Whitman, Benton & Franklin
Counties
1 800 542-1647
206 464-5933

▲
Statewide Central
Support Office
Seattle, WA
1 800 542-0794
206 464-5933

Native American Project (NAP)
Seattle, WA
206 464-0838

Institutional Legal Services
Project (ILSP)
Seattle, WA
206 464-0838

Farmworker Division (FWD)
Granger, WA
1 800 572-9466
509 854-1488

Other Legal Services Programs:

Puget Sound Legal Assistance
Foundation (PSLAF)
Tacoma, WA
206 572-4343

Puget Sound Legal Assistance
Foundation (PSLAF)
Olympia, WA
206 943-6260

Spokane Legal Services (SLS)
Spokane, WA
509 838-3671

Private Bar Delivery Models for Legal Services to Senior Citizens

Budget cuts in 1982 and again in 1986 forced Evergreen Legal Services to close field offices. Clients in areas where offices were closed are now served through a panel of private attorneys who contract with Evergreen to provide direct service delivery. The delivery model has several components.

I. PRIVATE BAR PANEL

Intake and Referral

Potential clients call Evergreen on a toll-free telephone line. One of two staff attorneys interviews the client to determine eligibility and problem type. Eligible clients with priority problems are accepted for representation. Eligible clients with low priority problems are given advice over the telephone and may receive written materials. Ineligible people, or eligible people with non-priority problems are referred to the Bar Association sponsored Lawyer Referral Service.

After a client is accepted for representation, he or she is referred to a member of the private bar panel. Attorneys are chosen based on geographical location and attorney interest and expertise. A staff attorney calls the attorney to make the referral, discussing the facts and legal issues in the case. A check is done to make sure the attorney does not have a conflict of interest and that the attorney has time to handle the case. After the attorney accepts the case, the client is notified and follow-up letters are sent to both the attorney and the client. The client then meets with the attorney and the attorney proceeds with appropriate representation.

Technical Assistance

In order to assist panel members in their representation of clients referred by Evergreen Legal Services, participating attorneys receive a variety of support services. Private Bar Panel staff attorneys are always available for consultation and assistance as representation proceeds. At the time of referral, the attorney receives an initial legal analysis of the case including citations to relevant statutes, regulations and cases. Panel members also receive other useful materials including entries from Evergreen's Brief and Pleading Bank and informational memoranda. As need and interest warrant, Evergreen provides training to panel members on topics which will facilitate handling of Evergreen referrals.

Payment

Panel members bill Evergreen Legal Services monthly for work done on Evergreen referrals. Evergreen pays a rate which is no more than 50% of the going rate in the local community. (This rate is $40 per hour in 1990.) Evergreen also reimburses attorneys for their reasonable out of pocket expenses, such as copying and long-distance telephone.

II. SENIOR LEGAL ADVICE CLINIC

The Senior Advice Clinic provides an opportunity for senior citizens with certain types of problems to have a free consultation with an attorney in a centralized location. Participating attorneys spend a maximum of four hours, one day a month (or less frequently depending on attorney availability) at the clinic. Evergreen pays the attorneys at the same rate as the Private Bar Panel for time spent in the initial client consultation and for a like time for follow-up to the consultation. (Additional time can be authorized where appropriate.) Clients are screened for problem type by Evergreen or by Senior Information and Assistance staff. The following types of problems are handled: Transfer of Assets for Nursing Home Medical Assistance, Debt Collection, Probate Appropriateness, Consumer, SSI Overpayments. The lawyer will give advice only. If the client desires representation, the client may choose to retain the clinic or any other attorney on a private basis or to contact Evergreen Legal Services for possible assignment of an attorney through Evergreen's Private Bar Panel. Evergreen provides training materials on those topics likely to be new to private attorneys.

VOL. : 90-2
DATE : Mar. 7, 1990
FROM: Sean Bleck

SENIOR BULLETIN: MEDICAID -- INSTITUTIONAL/COPES

DSHS CLARIFIES INTERPRETATION OF TRANSFER RESTRICTIONS

--Will Seek Federal Review of Position

The Department of Social and Health Services (DSHS) has interpreted the federal law setting periods of medicaid ineligibility for uncompensated transfers of assets in a manner which permits certain substantial transfers to be made with little or no adverse impact. At the same time, DSHS stated that it felt its interpretation (made in response to an inquiry by Evergreen Legal Services) was "inconsistent with congressional intent," and is seeking a further interpretation from the federal Health Care Financing Administration (HCFA).

The federal statute (42 U.S.C. §1396p(c)(1)), HCFA interpretive materials (State Medicaid Manual §3250.1), and the state regulation (WAC §388-95-395(6)) state that the period of inelibility is the number of months yielded by dividing the value of what is given away by the average private pay nursing home rate in the state. (If the result of the division is not a whole number, it is rounded down to the nearest whole number.) Further, the period of ineligibility is required to begin with the month in which the uncompensated transfer is made. The recent (March 2, 1990) DSHS interpretation is summarized and explained below:

1. *If less than the average private pay rate ($2036 in Washington) is given away in a month, there is no period of ineligibility, and there is no limit to the number of months in which such transfers can be made.*

Example: In **each** of the ten months before applying for medicaid institutional coverage or COPES, an applicant could give away $2,035 (or a total of $20,350 over the 10 month period) and not be subject to any period of ineligibility. ($2,035 ÷ $2036 = .9, which is rounded down to the nearest whole number which is 0.)

2. *Once a period of ineligibility begins, additional gifts made during that period of ineligibility cause concurrent, and not consecutive, periods of ineligibility.*

Example: A January gift of $5,000 would cause a two month period of ineligibility ($5,000 ÷ $2,036 = 2.45, which is rounded down to 2), beginning in January, and lasting through the end of

February. A subsequent February gift of $4,000 will cause a one month period of ineligibility (4,000 ÷ $2,036 = 1.96, which is rounded down to 1), February. Thus, there is no additional adverse impact from the second gift.

Example: A January gift of $22,395 would yield a 10 month period of ineligibility ($22,395 ÷ $2036 = 10.99, which is rounded down to the nearest whole number, 10) running from January through October. One could then make a $20,359 ($20,359 ÷ $2036 = 9.9) gift in February, a $18,323 ($18,323 ÷ $2036 = 8.9) gift in March, a $16,287 gift in April, a $14,251 gift in May, a $12,215 gift in June, a $10,179 gift in July, a $8,143 gift in August, a $6,107 gift in September, and a $4,071 gift in October **with no additional period of ineligibility.** In this fashion one can give away $132,330 over a 10 month period and become eligible in the eleventh month, or November in this example. Had one given away this entire amount in January, a 30 month period of ineligibility would have resulted.

3. *The total amount of gifts to all donees in any month are aggregated to determine the total amount given away in that month.*

Example. If one gives away $2035 to a son and $2035 to a daughter in the same month, there is a one month period of ineligibility. ($2035 + $2035 = $4070. $4070 ÷ $2036 = 1.9, which is rounded down to 1.)

PENALTIES FOR RECEIVING TRANSFERRED ASSETS REPEALED

The 1989 Legislature repealed the civil and criminal penalties for persons who knowingly and wilfully **received** assets for less than fair market value in order to enable an applicant to qualify for medical assistance. These penalties were previously codified at RCW 74.09.538.

No.: 90-2
Date: 3/30/90
From: B. Isenhour

SENIOR BULLETIN . . .
MEDICAID - INSTITUTIONAL/COPES

Re: Medicaid Resource Eligibility for Spouse on First Day of the Month

WAC 388-92-015(3) provides that resource eligibility for a Medicaid nursing home resident (COPES recipient) is determined as of the first day of the month. This means that a couple can have more than $62,580 on March 1, spend down their resources to $62,580 on March 3 and still will not be eligible for Medicaid until April 1st.

This rule appears to conflict with the clear provision in the MCCA, 42 U.S.C. §1396r-5(c)(2) that resources below the spousal exclusion of $62,580 be excluded as of the time of application for benefits.

A hearing should be requested for any married applicant adversely affected by this "first day of the month" rule. DSHS is reviewing this policy and considering removing the rule for both couples and single applicants.

We will continue to keep everyone informed on developments regarding this problem.

BA\90.MIC.bd

No.: 90-3
Date: 4/1/90
From: B. Isenhour

SENIOR BULLETIN . . .
MEDICAID - INSTITUTIONAL/COPES

RE: **Rent Reduction for COPES and Chore Recipients Living in Public and Subsidized Housing**

Public, HUD subsidized and Farmers Home Administration tenants, where the head of household or spouse are at least 62, are entitled to a reduction in rent if their medical expenses exceed 3% of annual income. 24 C.F.R. §813.102 and §913.102; 7 C.F.R. 1930 § Ex. B.

1. **What are medical expenses?**

Medical expenses should include the amount a COPES recipient must pay as "participation" in the program. Chore participation payments may also qualify as a medical expense.

2. **How do medical expenses reduce the tenant's rent?**

Rent in public and subsidized housing is 30% of the tenant's **adjusted** income. Medical expenses in excess of 3% of the tenant's income are deducted from the tenant's income **before** calculating the 30%.

> **Example:** Mr. Smith lives in a HUD subsidized building. His Social Security income is $700 per month. He is on COPES and must pay $266 per month for his COPES benefits ($700 - $434 = $266). The amount of Mr. Smith's participation that exceeds 3% of his income is $258. His adjusted income after deducting this medical expense is $442 ($700 - $258 = $442). Thirty percent of $442, or $147, is Mr. Smith's monthly rent. Without the deduction for Mr. Smith's COPES participation, his rent would have been $233 (30% of $700).

The same formula would apply for Chore recipients who have to pay for some of their benefits out of their own pocket. Clients should request an interim rent redetermination at the time they begin receiving COPES or Chore benefits so they do not have to wait several months to benefit from the reduced rent.

Case managers for COPES and Chore recipients should review all of their cases where the recipient has participation expenses and is living in either public or subsidized housing, to be sure the rent was properly calculated.

BAI\90-3.MIC:bd

No.: 90-5
Date: 4/10/90
From: B. Isenhour

SENIOR BULLETIN . . .
MEDICAID - INSTITUTIONAL/COPES

Re: Personal Items Included in Medicaid Payment

HCFA has published proposed rules listing personal hygiene items which are covered by Medicaid and Medicare. These items cannot be billed to a Medicaid or Medicare resident as sundry or miscellaneous charges. Examples of personal hygiene expenses include: shampoo and conditioner, combs, brushes, soap, razors, shaving cream, toothbrushes, toothpaste, denture supplies, dental floss, lotion, tissues, cotton balls, deodorant, incontinence supplies, sanitary napkins and supplies, towels, hospital gowns, over-the-counter drugs, nail care, hair cuts, shampoos, bathing, shaving and personal laundry.

See Federal Register 3/20, Vol.55, p. 10,256.

BA\90 5.MIC:lhs

EVERGREEN LEGAL SERVICES, 401 Second Avenue South, Suite 401
Seattle, Washington 98104 • • (206)464-1422

VOL. : 90-1
DATE : Mar. 27, 1990
FROM: Sean Bleck

SENIOR BULLETIN: MEDICAID -- NONINSTITUTIONAL

MEDICAID ELIGIBILITY FOR CONGREGATE CARE FACILITY RECIPIENTS

This bulletin explains how congregate care facility residents can qualify for Medicaid.

Although the costs of residing in a congregate care facility are reimburseable by DSHS for eligible clients, congregate care is not a Medicaid service. Unlike expenditures for Medicaid services, the state does not receive any federal matching funds for congregate care expenditures.

Also, client expenditures for congregate care are **not** medical expenses which can count toward the Limited Casualty Program -- Medically Needy (LCP--MN) "spend-down". But since CCF clients are required to spend almost all of their income toward the cost of their care, they do not have funds left over to pay for their medical expenses.

WAC 388-83-036 creates a special "Medically Needy Income Level" (MNIL) for congregate care (and adult family home) residents. That MNIL is the state cost standard (CCF or AFH reimbursement rate) for the facility **plus** the allowance for resident personal and incidental needs ($38).

The effect of this special MNIL, which is significantly higher than the MNIL of $414 for a single person in the community, is to make most CCF residents eligible for Medicaid with little or no "spend-down."

As a Medicaid recipient, expenditures made by a third person (typically family members) for supplemental services (i.e. those not covered by Medicaid such as a private room) directly to a provider of such services are not deemed income to the recipient for the purpose of computing the spend-down. (WAC 388-83-010.) However, under the CCF client participation rules, such expenditures will be deemed income unless an Exception To Policy is made by the local office, which is commonly done.

No.: 90-3
Date 3/7/90
From: B. Isenhour

SENIOR BULLETIN . . . VA

RE: CALCULATING INCOME FOR VA PENSION PURPOSES

In determining the amount of a VA improved pension, the VA takes the maximum annual pension minus "countable income". 38 C.F.R. §3.271.

The VA has recently changed its method of calculating the benefit amount when there is a change in countable income. The VA used to recalculate a veteran's benefit amount retroactively for the 12-month period from the date benefits began. This method created an overpayment whenever the veteran's income increased during a 12-month benefit period.

The VA has now agreed that, whenever there is a change in income, the benefits shall be recalculated prospectively only, for a 12-month benefit period beginning from the date the income changed. Veterans should challenge any overpayment resulting from the previous method of recalculating benefits.

The VA has also changed its method of calculating VA pension benefits when a veteran anticipates receiving Social Security disability or SSI income. The VA used to deduct the SSDI income from the VA pension amount as of the date the veteran was determined eligible for SSDI or SSI benefits.

Now the VA will only deduct SSDI or SSI income when it is actually received. The pension amount will be recalculated prospectively for a 12-month period from the date the veteran begins receiving SSDI or SSI checks.

No.: 90-6
Date: 4/17/90
From: B. Isenhour

SENIOR BULLETIN . . . VA

RE: VA Improved Pension Amount When Dependent Children Have Income

In calculating the amount of Improved Pension benefits, the VA subtracts "countable income" from the maximum annual pension rate. "Annual countable income" includes income of the veteran, spouse and all dependent children of the veteran.

VA regulations provide that the income of dependent children does not have to be counted if it would create a hardship. 38 C.F.R. §3.272. The VA will look at the family's reasonable family maintenance expenses in determining if the hardship exemption should apply.

The VA will only consider the hardship waiver of dependent children's income if the veteran requests it. Retroactive adjustments can be made for up to 2 years. 38 U.S.C. §3010(h).

BAI\90-6.VA:lhs

QUESTIONS AND ANSWERS ON MEDICAID FOR NURSING HOME RESIDENTS

Prepared by Evergreen Legal Services

Revision: April 2, 1990

> WARNING: The information given here is accurate as of the date of this revision. The rules can and do change. If you are contemplating transferring resources or are concerned about the application of these rules to your situation, you should obtain individualized legal advice.

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VII. CONCLUSION

THE MEDICALLY NEEDY ("SPEND-DOWN") PROGRAM
FOR SENIOR CITIZENS

The Medically Needy Program helps pay medical expenses for low income senior citizens and for disabled people who do not receive Medicaid coupons as part of an SSI, General Assistance or other public assistance grant. The full name of the program is "Limited Casualty Program-Medically Needy," abbreviated "LCP-MN." It is run by the Department of Social and Health Services ("DSHS"). Under this program, you can receive Medicaid coupons after you have spent part of your income on medical expenses.

(This brochure only discusses the program for people who are 65 or older, or who are disabled. Certain families with dependent children and pregnant women may also qualify for LCP-MN under somewhat different rules.)

Who Can Get Medically Needy Benefits?

You may be eligible for benefits if

you are 65 or older, or blind ordisabled, and

your income and property (resources) are very limited.

How Much Property Can I Have?

You can have a house (if you live in it) and basic household items and personal belongings. In addition you can have cash, bank accounts and other similar property up to a limit of $2,000 for an individual or $3,000 for a couple. And you can have an automobile worth up to $4,500 wholesale value. (If your car is needed for transportation to employment or medical treatment, is modified for use by a handicapped person or is needed for essential daily activities because of climate, terrain or distance, then there is no limit on its value.)

Ms. O'SHAUGHNESSY. Thanks, Arnie, for your observations about coordination of Title III and the legal services corporation.

I encourage you to look at Arnie's handouts that are attached to his statement: There are some interesting bulletins on public entitlements that I believe are addressed throughout the State for social workers, etc.

Our last speaker is Penny Hommel, who is the Executive Director of the Center for Social Gerontology, which is an AOA-funded national support project on law and aging. She is also director of an AOA-funded project on guardianship. Prior to her position at the Center, she was the Protective Services Specialist at the Michigan Office of Services to the Aging.

Penny.

STATEMENT OF PENNY HOMMEL, EXECUTIVE DIRECTOR OF THE CENTER FOR SOCIAL GERONTOLOGY

Ms. HOMMEL. Thank you very much. I am grateful to the Senate Special Committee and the General Accounting Office for inviting me to participate in this workshop "Barriers to Effective Advocacy: Ombudsman and Legal Services Experience." It is an honor to be here.

I was specifically asked to address two questions, and I have done that in my written remarks. One of those dealt with area agency oversight of legal services, and the second was on the types of data that are or ought to be collected with respect to legal services. Since responses to those questions are in writing, I will address them only if time permits, because I would rather take some time to make some general observations about legal services based on our work as a national support center in law and aging.

As Carol indicated when she began this half of the program, over the years Congress has increasingly recognized the importance of legal services, and has seen it really as almost an access service—as a means of ensuring that older persons have access to critical public benefits, to adequate housing, that there are protections for nursing home residents, and so forth.

We first saw evidence of this in 1975, when legal was designated as one of four priority services. The priority was strengthened in 1978, when it became one of three required services; and a requirement that "some funds" be spent on each of the three services was added. In 1981, again it was strengthened a bit with the priority continuing, but instead of "some funds," there was a call for an "adequate proportion" of funds to be spent on legal services.

In 1984, there was a beefing up of the waiver provisions so that in order not to spend money on legal services, area agencies had to demonstrate that the need for legal services was otherwise being met. Then in 1987, in the most recent set of amendments, the Congress indicated that every State is to set a minimum percentage of Title III(b) funds to be spent by each area agency on legal services; and the waiver provisions are linked to that minimum percentage.

So there has been significantly increased recognition by Congress of the value and the impact that legal services can have on the needs of older people. What we have seen as our Center for Social Gerontology has worked around the country with the State and area agencies and with the providers of legal services are outstanding commitment to legal services in some areas and some excellent examples of legal programs. And we have three such examples here today from Washington, Illinois, and an outstanding pro bono program from Arkansas.

However, we've also seen very underdeveloped and inadequate legal programs in many States and area agencies. A key reason for this inadequacy is that legal services remain seriously underfunded. The minimum percentages that have been set by the States since 1987 range from 1 percent to about 11 or 12 percent. The State of Washington is one of the highest with 11 percent. In some States, even those with no more than a 1 percent funding requirement, a number of AAAs are still getting waivers. We heard the figures on funding for legal services in Arkansas just a moment ago.

Even where area agencies are spending 1 percent, in some areas that translates into real dollars of no more than $1,000 per year for legal services. There are even a few States that—3 years after the 1987 amendments—still have not set a minimum percentage.

Linked to this, there is also a problem of maintenance of effort. In some States, where AAAs are funding legal services at a higher level than the State percentage minimum now calls for, the AAAs have the option if there is no maintenance of effort requirement, to decrease their level of funding for legal services.

So one of the major barriers—in spite of the priority that Congress has given to legal services—is inadequate funding at the local level. This, however, is not the only barrier that we've found as we've worked around the country. I think an equally important one is the lack of understanding by the aging network generally of the breadth of potential contributions that legal services can make to the lives and well-being of older persons.

The real problem here is, I think, that an understanding and appreciation of the value of legal services comes, in large part, from having good programs in place. Without existing programs that are doing the outreach needed to educate people to recognize their problems as legal, that are doing community education, that are targeting issues identified as particularly important, then there tends to be little demand for legal services, and thus little recognition of its importance.

Also, Roland Hornbostel mentioned earlier this morning that needs assessments for ombudsman and legal services are often found wanting, that is, older persons don't recognize that they have problems that are legal in nature and that a legal remedy may be available to them. This means that if you don't have high quality legal programs in place that are alerting people to recognize their legal problems, then there is no sense of need for legal services. This further aggravates a lack of appreciation by the funders of services of how important and valuable legal services are in ensuring that older persons have access to the rights and benefits to which they are entitled.

I think another critical barrier to effective legal advocacy confronting us today is the lack of meaningful targeting and outreach by many Title III-funded legal programs. Many programs consider outreach to be going out to the nutrition programs and the senior centers. Meaningful outreach, however must be carefully planned to reach groups that have been targeted as having the most serious problems that can be effectively addressed through legal services. This means going to the churches or to the migrant centers or wherever the particular group is that has been targeted. Similarly, community education efforts must be carefully planned to target particular issues and particular groups.

Obviously, some of the most important target groups, given our discussion today of linkages between ombudsmen and legal services, are nursing home residents and board and care residents. Our center has seen a few programs that are now targeting these two groups as well as other vulnerable groups such as the homeless, the abused and neglected elderly, persons at risk of guardianship. So we now have some very good examples of targeting by legal services programs. The challenge is to get those models replicated across the country.

Our center is also seeing—and I believe the area agencies and State agencies need to see more of this to be convinced of the importance of legal services—programs that are doing real impact work. That is, they are not satisfied to continually readdress problems on an individual level, but are looking for underlying systemic problems and trying to take on cases that will allow the legal program to work toward changing that system to benefit the entire group of older persons experiencing a particular problem.

Where there are programs in place that target their efforts and attempt to maximize the impact of limited resources, this generates increasing support. Where they do not exist, it is very difficult to get good programs and good levels of funding initiated.

One thing that all of these barriers suggest to me is the need for more statewide leadership, coordination, and education. This would mean that where there is a good program in one spot, area agencies in other parts of the State would be educated about that program and about its impact on the problems and needs of socially and economically vulnerable groups of older persons.

Beyond the lack of understanding of the contributions that legal services can make, I believe an equally important barrier to effective legal advocacy is a lack of understanding of what constitutes a quality legal program. An important activity of our Center is to go into individual States and assist them in developing their legal services. (Arnie mentioned that we came to Washington and worked with them to develop statewide standards for legal services.) Over a 2-year period, we are going into 25 States and working with them on their problems and issues as they identify them. One of the most valuable things we have learned in our work with the States is the importance of distinguishing between an area agency "contracting for a legal program" and simply "buying a lawyer's or a paralegal's time."

What we are realizing is that, with the minimum percentage requirements, a lot of area agencies are indeed meeting the requirement; but what they are often doing is to use the dollar amount that meets their particular minimum to buy a set number of hours of lawyer or paralegal time. They are not thinking about all of the targeting, the outreach, the community education, and other things that I've just mentioned that constitute a high quality, high impact, cost effective legal program.

Indeed, in some of these places, even where the level of funding has been less than $1,000, there has been a problem with the provider being able to spend that money. This is because if an area agency simply contracts for an attorney's or a paralegal's time, the people who walk in the door are the people who get served. Since the major problem that older persons tend to identify as being a legal problem is the need for a will and help with estate planning, that tends to be what walks in the door. And if there is no outreach or community education, and if the program is not easily accessible and is not visible to the community, very few people needing wills even walk in the door. As a result, we are placing increasing emphasis in our work with the States, on the distinction between a "legal program" and simply "buying a lawyer's time."

Based on there various observations about barriers to effective legal advocacy for older Americans, I would like to very quickly make a few specific recommendations with reauthorization of the Older Americans Act in mind. I would like to first repeat what Roland Hornbostel, the ombudsman for Ohio, suggested—that we think about the possibility of a separate title in the Act for advocacy services, both ombudsman and legal services. This could go a long way toward getting the statutory language that specifies "legal assistance" as a "priority service" translated into meaningful programs at the State and area level throughout the country. This would require making adequate funds available through that title to make quality legal services programs possible.

A second recommendation is to strengthen the mandate in the Act that calls for the State agency to provide leadership and training with respect to the development of legal services. The primary person that our center has been working with to plan our individual State visits is the State legal services developer. The more we work with the States, the more concerned we become about their capacity to provide leadership. There is very high turnover among developers and there is always a significant number of vacancies in various States. Where there is a developer on staff, many are able to spend only 20 to 30 percent of their time on legal services, with the rest going to a whole array of other unrelated activities.

In order to get the kind of statewide coordination and training, and the statewide standards that are needed to specify within the State what is expected of legal services, a full-time, qualified legal services developer is needed in every State. Without this, we will continue to have a very serious barrier to effective legal advocacy.

Third, I would like to suggest that—rather than asking the States to do it—Congress set the minimum funding level for legal services. That funding legal, however, needs to be more than a minimum percentage of Title III(b), because, as I said, a minimum percentage too often translates into a dollar amount that is for too low to support a meaningful legal services effort. What I would like to see considered would be a minimum percentage or a minimum dollar amount, whichever is greater.

In addition, given that Congress has consistently, since 1978 specified three services as priorities, it seems that Title III support for each of the three services should reflect that priority status, i.e., the percentage and dollar level for legal services should not be disproportionately low when compared to the percentages and dollar levels spent for the other two priorities access and in-home services. What we have found is that typically the percentages being required and spent for access and in-home services are substantially higher than what is being spent and required for legal services.

A fourth recommendation is that we think toward statewide or nationwide reporting that goes beyond numbers of "units of service" delivered, numbers of individuals served, and dollars spent. This information that is currently being collected on legal services is not going to give us very meaningful information. Legal is obviously a high cost service, and the numbers of persons served and the numbers of units of service being provided are going to be relatively low in comparison to other Title III programs, while the cost per unit is high.

I think what we need to begin to do in reporting is to try and get indicators that go beyond units, and really try to look at the impact of legal services. There are a couple of examples of legal programs around the country that are beginning to do this very effectively. One simple mechanism is to calculate the dollar benefits won for clients of legal services. Another is to measure that impact of legal services on maintaining the independence or dignity of older persons. This would involve getting reports on such things as how many evictions were stopped, how many guardianships were not restored to as a result of intervention by legal services, and so forth. Such an approach to reporting would begin to provide some meaningful indicators of the impact that an investment in legal services can have on important problems and needs of older individuals.

My fifth and final recommendation is that Congress, in the 1991 reauthorization, define in the Act some of the essential elements of high quality, high impact legal programs to be funded under Title III(b). The present definition of "legal assistance," i.e., "legal advice and representation by an attorney . . ." gives no guidance as to what constitutes a meaningful legal program. I would suggest that legal assistance be considered in the context of the broad advocacy mandate in the Act and that it be defined in terms of the critical role for legal advocates in responding to that mandate. Some examples of essential elements of legal programs that could be specified in the Act include:

> Careful planning and targeting to ensure that the most critical and timely issues and problems are given priority, and the most vulnerable groups of older persons receive service, with the limited resources available to the legal program;
>
> Coordination and integration with other key elements of the aging network in order to (1) identify the problems/cases and categories of older persons that need to be targeted, (2) receive appropriate referrals from nonlegal service providers in the network, and (3) make appropriate referrals to other service providers so that the legal and non-legal needs of clients are addressed;
>
> Careful consideration of issues of access, along with planning and targeting of outreach and community education efforts, to ensure that those most in need of assistance (1) are aware of

the legal program, (2) understand how the program can assist them, and (3) are able to easily avail themselves of the program's services.

[The prepared statement of Penny Hommel follows:]

Barriers to Effective Advocacy: Ombudsman and Legal Services Experience

Statement of
Penelope Hommel, Executive Director
The Center for Social Gerontology, Ann Arbor, MI

Since the passage of the Older Americans Act in 1965, there has been significant progress in increasing the delivery of legal services to older persons. Each reauthorization of the Act has heightened the focus on legal services at the State and Area Agency levels. From our Center's work with State and Area Agencies in recent years, however, I have become convinced that the two most important barriers to effective legal advocacy are:

-- the level of Title III funding remains much too low, generally, for there to be real legal programs;

-- generally, the legal programs which are funded are not viewed as integral parts of the other aging network services funded by the AAAs. Until they are, their role as significant parts of the AAA and Aging Network advocacy efforts are minimal.

When AAAs and legal providers work as real partners in advocacy for the elderly, the contribution of legal services is greatest, and this is recognized and rewarded by the AAAs. Further, where this occurs, we also generally see that the AAA and legal provider are truly targeting services to those elderly who are most socially and economically vulnerable -- just as the OAA requires.

Specifically I have been asked to address at this workshop two aspects of legal services:

-- Area Agencies on Aging oversight of legal services

-- The types of data that are or ought to be collected with reference to provision of legal services.

Area Agencies on Aging and Oversight of Legal Services

As The Center for Social Gerontology works throughout the country, a persistent source of frustration for many area agencies, and on which we are very frequently asked for help, is monitoring and evaluation. Many AAAs are hesitant and uncertain about their capacity, as non-lawyers, to monitor and evaluate the legal programs they fund. While there is validity to the belief that non-lawyers cannot effectively assess the quality of the legal work and case handling of lawyers, there are many organizational management and operational aspects of a legal program that can be readily assessed by AAAs if they incorporate legal into their overall planning process. These include: (1) assessing compliance with the Older Americans Act and its regulations; particularly the Act's requirement to target older persons in greatest social and economic need; (2) determining that certain prerequisites of an effective delivery system (outreach to targeted populations, community education and accessibility) are in place; and (3) determining that certain management and operational systems are in place for the delivery of services.

In the annual planning process, AAAs, their legal providers, and other service providers should assess which issues and which sub-groups of older persons need to be particularly targeted. The roles of the AAA, the legal and non-legal service providers should then be analyzed and a plan developed for cooperative, coordinated efforts to address most effectively the chosen issue(s) -- be it nursing home problems, elder abuse, guardianship, access to SSI benefits, or advance directives for medical decisions. Given this kind of planning, the AAA and its Board will have a very good sense of what they are buying; and the monitoring and evaluation will flow fairly easily from that.

An essential piece of the monitoring will involve looking at the extent and ways in which the target issues are being addressed by the legal program, and the numbers and percentages of clients that fall into the identified target populations. Specifically this involves such things as:

Evaluating Outreach, Community Education, and Accessibility
No program -- no matter how competent its staff -- can have an impact if potential clients do not know of its existence, do not recognize the legal nature of their problems, or if the legal services are not easily accessible to them. Outreach and community education activities should be focused, in large part, on the issues identified for targeting and should be conducted in locations where the targeted populations are likely to gather.

Evaluating Service Delivery

Although there are a variety of models for providing legal assistance, there are a number of aspects of management and operation that bear on the capacity of any model to deliver effective legal services. These can and should be evaluated by AAAs with particular attention to how well the management plan and operating procedures address targeted issues and populations. These include:

- Management systems for quality control. Quality control mechanisms that should be in place include: (1) standards governing the number and types of cases handled by staff; (2) systems for regular monitoring and supervision of cases; (3) a process for sharing substantive or procedural expertise; (4) procedures for keeping records, handling client funds, informing clients about their cases, and preventing conflicts of interest; and (5) a good fiscal management plan.

- Staff and Staff Training. Because the field of law and aging is relatively new, few legal workers are specialists in the many and complex substantive areas which vitally affect older persons. Also, few have training in how to work effectively with older clients. Thus a quality program will offer regular staff training and support in key areas of law and advocacy skills.

- Adequacy of Library/Legal Research Materials. Quality legal services requires easy access to a well-equipped library, and certain basic materials related to the areas in which the program practices should be available in the office.

- Adequacy of Office Facilities and Equipment. A program's offices should be clean, comfortable, and professional in appearance, and offices used to interview clients should be private to ensure confidentiality.

- Coordination with Other Legal Resources. Title III is intended to supplement existing legal services. Thus, a good program should coordinate efforts with the local Legal Services Corporation program, and work to develop private attorney involvement -- whether Pro Bono or for reduced fees.

- Coordination with Non-Legal Community Services. An effective program recognizes that many older clients have non-legal problems that require referral. It should be coordinated with a wide array of non-legal service providers in order to make referrals whenever the client consents.

The Types of Data That Are or Ought to be Collected with Reference to Provision of Legal Services

In the area of reporting there are a number of issues that should be considered in Reauthorization of the Older Americans Act. These include (1) problems with confidentiality and unduplicated counts; (2) problems with undercounting given the definition of legal assistance; and (3) the importance of trying to capture data and information that will give an indication of the impact that legal services are having on the lives and well being of older persons.

1. Problems with Confidentiality and Unduplicated Counts

The 1987 Amendments to the Older Americans Act require, among other things, that the number of individuals who received each type of service under Title III of the Act be reported. This requirement has been interpreted to mean an unduplicated count, which means that a client who receives services more than one time during the year is only counted once. In a number of places we have visited throughout the country, there has been a problem with state or area agency reporting formats requiring names of individuals served. This is to allow them to get an accurate unduplicated count to report to the Administration on Aging and to Congress. This is problemmatic in that it violates attorneys' professional ethical requirements as well as the section of the Older Americans Act that protects the identity of legal services clients as confidential information that is not to be divulged by legal providers.

The Administration on Aging, in its reporting format that was disseminated to all state agencies on aging, has addressed the problem by calling only for a "best estimate" of unduplicated client counts. Thus it is possible that legal providers could count the number of unduplicated clients and supply only that number -- without names or identifying information -- to the AAA. However, because we know there are some state and area requirements for names of clients served, in the Section of the Act that describes reporting requirements, the 1991 Amendments should clarify that client identities are confidential and should not have to be divulged to state or area agencies.

2. The Problem of Undercounting

Given the definition of "Legal Assistance" in the Older Americans Act -- which is used in AoA's Reporting Format for state agencies -- we have discovered in our work around the country that the activities and services of some legal providers are being seriously undercounted. Because the definition is limited to "legal advice and representation," many activities that are critical to effective targeting and to a successful program are not being reported and counted as legal services. In keeping with the definition, AoA's reporting format lists as categories of services separate from "legal assistance" the following:

Advocacy/Representation (1 HOUR) -- Action taken on behalf of an older person to secure his/her rights or benefits. Includes receiving, investigating and working to resolve disputes or complaints. Does not include services provided by an attorney or person under the supervision of an attorney (emphasis added).

Education/Training (1 HOUR) -- Providing formal or informal opportunities for individuals to acquire knowledge, experience or skills. Includes individual or group events designed to increase awareness in such areas as nutrition, crime, or accident prevention; promote personal enrichment, for example, through continuing education; to increase or gain skills in a specific craft, trade, job, or occupation. . . .

Information/Referral (1 CONTACT) -- Includes the provision of concrete information to a client about available public and voluntary services/resources and linkage to ensure the service will be delivered to the client. Includes contact with the provider.

Outreach/Client Finding (1 CONTACT) -- Intervention initiated by a provider to identify clients and to encourage the use of existing services and benefits.

Because each of these services is an essential part of a quality legal program, they should be counted as "legal assistance" when carried out by the legal provider. If this is not done, there will be a very low number of units of legal services provided as compared to other services, and the cost per unit will appear to be substantially higher than it actually is. A straight cost benefit analysis of these statistics could result in legal services appearing to have less impact and importance for older persons than other Title III services.

3. The Importance of Trying to Capture Data Indicating Impact

At present the Older Americans Act calls for data on the number of persons receiving various types of services, the number of units of each type of service provided, and the amount of money spent for each type of service. While this will yield important data not previously available to Congress, these statistics will not in any way illustrate the value and impact of legal services on the lives and well being of older persons. Ideally we need information that will give some indication of impact such as saving a public housing resident from losing her home; obtaining a Social Security entitlement for a widow who otherwise would have no income; challenging successfully the denial of an older couple's application for food stamps; appealing and obtaining Medicare or Medicaid payment of a hospital bill, thus preventing the former patient from having to pay for services from his or her pocket; or defending an older person from an unnecessary guardianship.

It would be very useful and telling if Congress would request information reflecting the value of legal services both in monetary and human terms. Two important types of information would be (1) the dollar value of benefits obtained or saved for a client as a result of legal services rendered (e.g. an SSI or Medicare payment); and (2) the number of cases in which the provision of legal services has resulted in protecting the client's life, health, homestead, dignity, or independence.

Ms. O'Shaughnessy. Penny, thank you very much. It's very good to get the perspective of someone who has worked with legal services for so long and who is from the national back-up center.

We're very pleased that Senator Brock Adams has joined us in this session on legal services. Senator Adams has just assumed the chairmanship of the Subcommittee on Aging of the Labor and Human Resources Committee, which will be responsible for reauthorization of the Act in 1991, and I believe he has some comments for us.

STATEMENT OF SENATOR BROCK ADAMS

Senator Adams. Thank you very much. I am not here today really to participate in the workshop but simply to let you know that I exist. One of my best friends in the U.S. Senate, and I won't tell you what we all call him or refer to him as, but it is with great affection, is Senator David Pryor. He has carried great responsibility in this area, and I just want David to know, and all the rest of you to know, that I'm looking forward to sharing this responsibility.

The Older Americans Act will be a key priority of mine. We will miss Spark very much, but I will try to fill his shoes and be very active in this field. I want you to know that one of my first acts as subcommittee chairman was to go over and raid Senator Pryor's office. Bill Benson will be heading the staff for the committee and will be in charge of seeing that we get the Older Americans Act reauthorized.

Do you understand that, Bill? [Applause.]

Senator Adams. A great many of you know Bill and therefore will understand that we are very serious about the OAA. We didn't want to go through a learning curve, we wanted to jump start our activities. This will be possible with Bill Benson on board as staff director of the subcommittee.

I also am very pleased today that Arnold Whedbee of the Evergreen Legal Services is with us. We are very proud of Evergreen Legal Services in the State of Washington, and I can tell you how proud we are. When I was in the private practice, we hired the head of Evergreen Legal Services to come down and administer our legal office. So, I know from first-hand experience that they are very, very highly respected.

I can remember the days when we started Evergreen Legal Services. I was U.S. District Attorney in Seattle at that time, and one of our chief complaints was that we had very inadequate services for those who couldn't really afford—and nobody can afford a lawyer now—but couldn't afford basic services. Evergreen Legal Services has been an outgrowth of the public defender system and has grown to cover more areas. We are proud of some of the innovative things we have done with Evergreen Legal Services.

We have a long ways to go. But I want you to know that we are not unfamiliar with the OAA. So, that's why I'm here today. I want you to know that I exist, there is a new committee chairman, the new committee chairman is friendly, he is a good friend of David Pryor, he has a staff director that you are all acquainted with, and that the State of Washington is great and wonderful place, and we are very liberal. Thank you. [Laughter and applause.]

Senator ADAMS. Thank you all, and I apologize to your speaker. I have never heard a speaker stop so quickly in mid-sentence, and my both apologies and congratulations.

I might say that David is the one that has saved us. David is the head of the quality of life committee. The quality of life committee is devoted to just that; trying to see that, one, we see our families once in a while; second, that a bill moves once in a while; and above all, he has gotten out of presiding 3 or 4 hours a day. I only have to do three a week, and this happens to be one of mine. Thank you very much.

Ms. O'SHAUGHNESSY. Well, this, again, is the time that we turn the presentation over to you all and ask for questions, discussion, comments. Also, additional comments from the panel may be appropriate, so do we have any questions from the audience?

Would you please approach the mike and if you would just give your name and organization, please.

STATEMENT OF NANCY COLEMAN, DIRECTOR, ABA COMMISSION ON LEGAL PROBLEMS OF THE ELDERLY

Ms. COLEMAN. I'm Nancy Coleman. I'm the Director of the American Bar Association's Commission on Legal Problems of the Elderly. I think it's wonderful that you're having the hearing today.

Congratulations, Bill, on your new position.

It's very interesting to me that in today's Ann Landers that we are learning about what legal problems are of older people. It's amazing to me that over the last few months I think that the American public has learned more from the public press and more from the results of Monday's decision in the Supreme Court and from L.A. Law what legal issues are in this country.

Let me just review that for a second. As of Monday, now, older people and those of us that are thinking about what's going to happen with our future need to write them down, need to write our opinions down. We did some work with Ann Landers in mid-March with AARP. She ran a column on health care powers of attorney and said that people should write for a little booklet that we had written, and 120,000 people wrote to AARP for a free copy of that within 1 month.

So it is amazing to me that the popular press raises the legal issues and legal awareness. As we begin to talk about these issues with regard to the Older Americans Act, I am struck by today's column, and I'm struck in this manner. An older woman cites that she gave away in a marriage that took place in 1967—her husband decided that he'd sell his house and put everything in assets, set up a trust that was only in his name and his children's name, they've lived together and been married for the last 23 years. If he dies, she is left with her $227 a month in Social Security and no other assets other than her house.

Now, what I'm struck by is that Ann Landers says go find an attorney, but she doesn't say go find your Title III attorney, go find your Legal Services Corporation attorney, go to the Bar Association, go someplace else. The situation is that we're looking at a variety of delivery systems which the American public, our older population, is not aware of. If we are learning about legal issues and legal problems from the popular press, from L.A. Law telling us about guardianships, from those kinds of things, where is it that we find out about it?

If, in fact, people can find the AAA in their blue pages or yellow pages of their phone book, they might get the Title III person, but if you called Arnold's program, which is, again, one of the most outstanding ones in the country, and she asks for help with a will, she's not going to get that from his program. If she calls the Title III program in Arkansas, she may get it if she gets over to the appropriate pro bono attorney, but there are lots of steps there.

So, again, the difficulty is—and she's not going to get it if she calls the Legal Assistance Foundation, because they don't do wills, period, but it may be that she doesn't want a will, but that's what she has asked for. So let's begin to look, as we look at the reauthorization, as we look at the delivery system question, how we can begin to integrate the question, which is really going through the AAA in large part, to Ann Landers or wherever about what it is that somebody is asking.

Are they really asking for a will, are they asking for a division of property, are they asking for something that's really much more subtle, and that's really some legal planning and legal thinking, so that they are not left at that $227 a month of total income.

Ms. O'SHAUGHNESSY. Thank you.

Other questions, comments?

STATEMENT OF SUSHIL SHARMA, GAO

Mr. SHARMA. I think I want to expand a little bit on Ann's comment. I think it's a very good comment. We do have multiplicity of services, the range of the services that we are offering to the elderly people. I also want to make a comment on Dr. Cohen's speech earlier about moral versus legal obligations, and my question is, if we do have some problems, how do they need to be resolved. The solution lies mostly in the legal arena that is having more ombudsmen, more legal advocates or more regulations.

What are our moral responsibilities? Why are people in the situation the way they are? I don't have the answer, but I think this is a question we need to answer or at least begin to talk about, considering the fact in the year 2000 we are going to have over 4 million—and this is a very conservative estimate—people who are over 100 years old, and these are the kind of people who are going to be requiring more and more assistance.

Another point of view that I think we need to begin to talk about is before people have a need for legal services, what factors precipitate them to require legal services? Who are other actors who are in this service system? I think I also want to make a mention to Senator Pryor's opening statement in the first seminar, where he described the Older Americans Act as a model act of this society, of this decade.

I think one of the neat things about the Older Americans Act is that it's really talking about the quality of life for the older Americans. There's a whole range of services that are being offered under the Older Americans Act. In the earlier presentation, we talked about the abuse and neglect that's occurring in the board and care facilities more so than in nursing homes.

There are also a number of social service providers who are available to these individuals who are, at least, supposed to make frequent visits to these facilities. What is their role? What is the link between the social service provider and the legal service provider? If the purpose of this Act is to coordinate these services, how is it being done? How is information about abuse and neglect being disseminated to the public? Is it through Ann Landers or is it through some formal system, such as AOA or AAA? How is this system working? I'm just raising all these issues, and I'm hoping that we'll be able to address some of these issues.

Mr. **Manley**. This is not an uncommon question and concern. We've addressed that in Arkansas, and I don't know that we've ever been able to resolve it. I raised the issue at the end of my comments about possibly the role of the ombudsman.

My interpretation of the Act requires that legal assistance be either an attorney or someone who works under the supervision of an attorney. The problem you have is that if you have nonlawyers or somebody you want to call a "paralegal," who could be anybody, that can go to a nursing home and talk to people, the problem is that most of the elderly people that we deal with do not know if it's a legal problem.

You know, if their Social Security check gets stopped, is that a legal problem? Is that a bureaucratic problem? Did somebody just mess up? Did they decide that that person was no longer eligible? Did they give them the right notices? Or if the Social Security check is stopped because the system has gone bankrupt, I don't know if that's a legal problem. That's a political problem.

So if you have nonlawyers going in and talking to these people once a week or once a month about just how are they doing, what's going on here, they don't know that there may be something going on that an attorney can help them with, but if the nonlawyer can bring that information back to an attorney—I'm not advocating that we send attorneys to the nursing homes every week, but let them see if that's a social problem, is it a legal problem, is it a problem with the bureaucracy that we need to sue the bureaucracy in order to get that problem resolved for everybody in that nursing home and every other nursing home?

We've always felt that we've done the Lord's work for quite some time. That may be a fairly arrogant attitude, but we are serious about our clients. We try to help people, and that's what we're in this business for. Unfortunately and fortunately at the same time we have a lot of restrictions on what we can do.

I'm not sure that we could go out and advertise what we do and tell people if they need that. I know the private bar cannot do that, and they have a lot of restrictions on them. I don't know about the moral issue. Why do we need ombudsmen? Why do we need to go in and see if the nursing home is doing their job? I mean, in a perfect society we wouldn't need that, but, unfortunately, we do. Whether that's a legal problem or social problem or moral problem, I don't know.

Dr. COHEN. Betty Friedan, who is a mentor of mine, took an approach which wasn't to suggest that women go running to lawyers to vindicate their rights. The most important observation that Betty Freidan gave us was the recognition that traditional roles for women were not enough. It was not fulfilling. And it was that first recognition that then led into a whole set of legal and changes in practices which might not have been compelled through law.

I would like to suggest that it is appropriate for ombudsman and legal services programs to sit down with not just the HCFA people and not just the State health departments, but with older people, with relatives, and the first thing we have to do is to say what is it that really represents first rate nursing home care for those who need it?

Let's forget what the law requires, because once we do that first thing and can articulate that, we will quickly see that which law can compel and that which we must attack through other means. I respectfully suggest that we overlook that step and that we have not gone very far from counting things and counting hours of staff time for patients, taking the quantitative notions, and we add it all up, that will be a good nursing home.

That, I submit to you, it may be necessary, but, as the lawyers say, it's insufficient. Very, very insufficient. If we did everything that the Institute of Medicine suggested, if we did everything that OBRA requires, if we made sure that we could check off every one of those things, it would not be enough.

There is that first step, and that will lead us to some understanding of what we want from the nursing home profession. What do we want from a director of nurses in a nursing home? I don't see that anywhere in any of the materials from health departments, regulators. What do we really want from that director of nurses?

We want some sense of what this place ought to look like, sound like. You can't regulate the nature of sound. Those of you who have been in nursing homes, you know there are good sounds and there are not so good sounds, and we all know what they are, and you can tell the difference. You can't regulate that. I don't care how smart we are or if we get 100 lawyers in the same room, God forbid, we'll never get that.

This is the first step we've got to take. Where are the goals? What happens if we're 100 percent successful? Then, how do we impart that to directors of nurses, to OTs, PTs, administrators, aides? I've been in homes where the aides have superb view and vision, and I think there are ways of imparting that. We've done it in mental retardation in a number of places. We've changed that system very, very radically.

We've used tools of law, and in very creative ways, but we've also done some other things. Some things with parents, and sometimes parents have to have their postures changed. In the Pennhurst case in Pennsylvania, we had parents organized to keep people in the institution. In fact, the mother of the named Plaintiff in that case, in fact, did not want her daughter moved.

There's a lot that has to be done, but it has to do with changing moral goals, and that is absolutely not to say that legal services and legal tools aren't important, but the synergism that we can get out of this is just tremendous.

Ms. O'SHAUGHNESSY. More comments?

STATEMENT OF JIM BERGMAN, EXECUTIVE DIRECTOR, HEALTH WAYS FOUNDATION OF NEW JERSEY

Mr. BERGMAN. I'm Jim Bergman. I'm Executive Director of the Health Ways Foundation in New Jersey. I'm reminded of the play "1776," where John Adams starts out by saying I've come to the conclusion that one useless man is a disgrace, two useless men are a law firm, and three or more are a Congress. I think that the point of John Adams was that, in fact, there are two groups that don't have a particularly good reputation in this country. One is lawyers, the other is Congress.

How that fits in with what we're doing today, I think, is that we're dealing here with barriers to effective advocacy, especially legal advocacy. In my judgment, in going around the country talking with AAAs and talking with State agencies, as much as anything it's because legal services have never been viewed as an integral part of the aging network.

You fund in-home services, we fund transportation services, and everyone has a gut feel for what that means. You don't have to be a bus driver to know what transportation is. You don't have to be a homemaker to know what homemaker services is. But most people in AAAs and State agencies don't really have a feel for what legal services are, and as a result, when Title III money is funded, it goes in bulk to transportation and to in-home services, and then like Pluto's moon, a little bit maybe goes out to legal services.

When the are agency board is asked by someone who is saying we need more transportation why are you giving that legal grant, they sort of scratch their heads and apologetically say, well, they do some wills, and it doesn't go too much further very often.

There's a failure, I think, that is going on there, and it's a failure on both sides. The area agencies are not really finding out what legal services means, and the lawyers, God love us, do a terrible job of communicating what lawyers do. I know when I went to law school I was told that, at some point, I was going to think like a lawyer, and if anything came out of my law school career, it was going to be I was going to know how to do that. Like every good law student, I'd go home every night, and I'd go to bed, and I'd say tomorrow morning I'm going to wake up and I'm going to be thinking like a lawyer, and one morning I knew I did it, and then I couldn't figure out what it was.

I think finally years later I discovered that what it really meant was that I viewed the world in terms of rights. It's impossible for me to identify any issue without thinking about whose rights are being violated and how you remedy those rights. If anything, what we need to be doing—and I think Eli is right, legislation doesn't do this—it's really giving people an understanding and giving AAA individuals an understanding that they need to view legal services as protection of rights. They need to build it into their area planning process, just as they built it in the transportation and the homemaker service.

In a way, what they have to do is see that the problems that they identify in their area planning process need to involve that legal program, and, in fact, what they contract for legal services should fall directly out of that planning process. It sounds so simple, but it doesn't happen. If they identify this is the year that they're going to go after nursing home problems or guardianship problems, what should fall out of that is that the legal program should be funded, at least partially, to focus on that issue and to be a part of the area agency's overall thrust to do something about guardianship problems or nursing home problems or elder abuse problems.

Yes, still do some direct services, some will, some property transfer stuff, whatever. Politically or because people really need that, do the public benefits, but begin to see it as a legal program as you're doing in Washington and as we did it in Massachusetts back in the mid-1970's. Massachusetts went from very little money in legal services before the Older Americans Act mandated anything to $1 million in Title III money going to legal services. That was 16 or 18 percent.

I don't know if they're still there in terms of that amount, but it got there for a very simple reason, and that was we worked with the area agencies, and the legal services programs got together and worked together and said we're in this as an advocate effort. We're not selling legal services. We're selling advocacy. You're got problems, we've got problems, let's do it together, and the grants started coming, with the opposition of the State agency at that time who didn't like to be sued.

But the money went, and that was actually an impetus for it. What also happened was that an elderly legal coalition got formed, and it was not just the lawyers and the paralegals, it was the AAAs and it was all the advocates in the State who saw it as a way of focusing on advocacy.

My recommendation for the reauthorization is that we don't need an awful lot more language in there. I think getting a waiver should be damn near impossible, because no one is meeting the needs, and we know that, but maybe what needs to be done is to view this as advocacy. Maybe Penny's right. Maybe there does need to be a separate title that deals with advocacy, but maybe another way also is to say that the area plans specifically have to have an advocacy portion of that plan, and it's got to have within it the legal services piece and the other advocacy efforts to the AAA.

They're supposed to be focal points, and they're supposed to be advocates, and they are, but maybe that plan has to specifically say how the legal program is going to be a part of that, and maybe that's how the discussion begins to get going on that local level about how to get legal services really integrated into the total Title III aging network. Thank you.

Ms. O'SHAUGHNESSY. Does anyone on the panel have a comment?

Ms. FISHER. I just have a real brief sympathetic note on that. Our local area on aging recently got some supplemental funds from the State and sent out some requests for comments on how they should spent it, and they had identified as priorities income maintenance, health care, and maintaining homes for the elderly, and it simply did not occur to them in any way, shape, or form that legal services had any bearing on any of those priorities.

It was just enormously frustrating sitting in a legal services program where we do enormous amounts of housing work, enormous amounts of health care work, enormous amounts of income maintenance work, so you're right, and, obviously, anything we can to address that is worth doing.

Mr. **Manley**. One of the things I've noticed in all the literature is that there are not a whole lot of statistics out here about what kind of legal assistance do the elderly need.

One of the things attached to my exhibits is a survey that the State of Arkansas did, and I have no idea what their survey looked like, what their questions looked like, but they got 14,000 elderly people just in Arkansas who said their main priority was legal assistance.

Based on the number of people in Arkansas, that's not a whole lot, but when you think about it, that's an incredibly high number, because at that point in their life they needed what they perceived to be a legal problem. They may not have that legal problem 6 months from now, they may be on the street 6 months from now.

But, to me, we're going to have to develop some kind of a statistical measurement somehow to develop these numbers in order to convince folks that there's certainly a need out there. How great a need, I don't know. My personal belief based on my experience is it's an incredibly high need, but it's certainly an unmet need at this point.

Ms. **O'Shaughnessy**. I believe we had a question from Elma?

Mr. **Holder**. Well, I'm glad it's an open mike, because I feel compelled to make some comments. I just want to give some good news to Dr. Cohen. I do believe that the nursing home reform law is built on what residents and family members have been letting us know for the last 15 to 20 years. I feel very comfortable with that.

Our own organization held discussions as you suggested, which I think is a good idea since we've done it, we held discussions with nursing home residents throughout the country, and we developed a report that was submitted to the Institute of Medicine, and it was what residents want in nursing homes from staff, from the survey agency, from the ombudsman program, from everybody.

It was the voices of residents, which were collected and very, very articulate about good care in nursing homes. I know other people have done followup work on that work. I believe that, even if this is a quasi kind of public record, I do want to be able to say that the new reform law lays out the tendency for good nursing home care based on good care practices that we've known about and that we've seen in good nursing homes for many years.

So I believe that what we're dealing with is a public policy that is pretty much outstanding except for a few little missing pieces here and there, and I think in connecting it with what we're doing here to day and what we certainly started out with. I know that, as I said earlier in the session, the ombudsman program and its presence on a daily or weekly basis is going to be critical to implementing that law as we try to start that in October, and legal services, undoubtedly, is going to become involved at different points in it, and I believe it's far beyond a matter of regulation or over-regulation.

I think we've done an outstanding job that we should be proud of publicly to put this law together with its quality of care, qualify of life, residents' rights, resident assessment, everything that's there that's needed to guide people to give good care, and I just think that the programs that we're talking about today are going to be a part of that, so, once again, I would urge good support for the ombudsman program and, certainly, legal services, and what people on this panel have been saying our organization would also go on record to say that anything we can do to beef up your programs, we'll support.

Ms. O'SHAUGHNESSY. Two more questions in the back, if you want to approach the mike. I don't think those mikes are working. If you could just give your name and organization for the recorder.

STATEMENT OF ALFRED CHIPLIN, NATIONAL SENIOR CITIZENS LAW CENTER

Mr. CHIPLIN. My name is Alfred Chiplin. I'm a Staff Attorney at the National Senior Citizens Law Center here in the Washington office. One of the things that I find interesting in this discussion, particularly as it relates to finding ways to get services to individuals, is the whole question of under the Older Americans Act currently there is no provision for an individual to exercise any of the principles under the Older Americans Act in terms of a private right of action, to, say, go in and, you know, I don't like what's happened or I've been kicked out of that service or I want more things or whatever the issue might be.

While that is a very controversial issue, I think this the time to begin to plant the seeds of some kind of discussion so that that part of the package can be pulled together. If you look at all of the other statutes that we talk about that look at this whole merger of the ethical and the legal, there is some way for individuals who are the ultimate beneficiaries of those statutes to exercise and at least ring the bell and say let's have something done about a particular issues.

I would invite all of us as we look at the whole reauthorization process to begin to weigh some methods, a variety of methods, that might allow for that kind of individual input. I know that was debated to some degree in the last reauthorization process, and it fell on deaf ears. People were really frightened of it. But I do think we need to look at that, because, otherwise, what we've been talking about, this merger of law and ethics and the whole sense of philosophy of how people move as a society, if the individuals can't initiate it, I don't see where it goes. Thank you.

Ms. O'SHAUGHNESSY. One more question?

STATEMENT OF NORMA PINKLETON, HAMPTON UNIVERSITY

Ms. PINKLETON. Yes, I have a question and a statement. I'm Norma Pinkleton from Hampton University, and I'm the Director of the Gerontological Nurse Practitioner Program. I'm very pleased to be here, because you're bringing forward a variety of issues, and I know as a part of the program, as I set it up, I did include legal services as well as ombudsman, and I've been very active in all forms of advocacy with Legal Women Voters and Peninsula Mental Health Association, and also in terms of leadership direction for students, in order to elevate a lot of the issues that you are talking about here.

But when you're talking about coordination and you're talking about quality, don't forget the whole manpower issue, and underwriting that in terms of costs, that all of the factors that you're talking about are implemented in the day-to-day services, and these are primarily services that are equated with nursing care services in some form or another.

And I know that's a big issue, and it's hard for us to even address that issue from a variety of perspectives, and one has to do with salaries and costs, so nothing happens again without someone who is prepared to implement that on a moment-by-moment and a day-to-day basis as well as being able to interpert what the client is saying as to what their needs are and knowing how to refer them appropriately. I think nurses and persons who are appropriately trained have the capacity to do that.

I also would like to know how I can access the new nursing home regulations that are coming out in October so I can make sure that becomes a part of my educational program. Thank you.

Ms. O'SHAUGHNESSY. I have a last call for questions, comments. Bill.

STATEMENT OF BILL BENSON, STAFF DIRECTOR, SUBCOMMITTEE ON AGING

Mr. BENSON. I'd like to direct two legal services questions to the panel. One was mentioned earlier today. The Special Committee on Aging, in conjunction with the National Senior Citizens Law Center, has done a survey of legal services programs across the country, and I know that the results are preliminary and we're still looking at those, but one of the things that struck me under the category of types of cases, the statement here that we've got so far is "although the types of cases that are handled by legal services programs vary from State to State, the four most common types of cases are consumer protection, housing, advance directives, meaning durable power of attorney and living wills, and estate and probate matters."

When I saw that, I was flabbergasted, and I was flabbergasted because it didn't include what I would have assumed would have been the most common area, which would have been public entitlements: SSI, Social Security, Medicaid, Medicare, disability, and so forth. I'm startled by that, and maybe that reflects things that are changing out there, so I'd like some reaction to that.

My second question is, if I can just leave it out here and go sit down, is there a view out there, is it a reality out there, that it's deemed by some that funding of programs to provide nonlawyer advocacy, however that's defined, without an attorney somewhere onsite or in the wings, can that be deemed to be legal assistance or legal services in any way? Is there an argument being made across the country anywhere that that's possible? Does that meet the test of legal assistance, or is there an argument that it ought to meet the test? So let me leave those two questions for you.

Ms. O'SHAUGHNESSY. Does someone on the panel want to address the question that Bill has raised about the types of cases?

Mr. WHEDBEE. Well, other people may want to respond, too, but in terms of our program, we provide it as part of our material. I think the breakout of our cases that we handle are housing, 19 percent; health, 35 percent; guardianship, 10 percent; public entitlements, 14 percent; consumer, 8 percent. So I don't know about what other people are doing.

Ms. **Hommel**. I guess I am not that surprised about the types of cases; and I think it goes back somewhat to the point I was making about the difference between contracting for a lawyer's time and contracting for a legal services program. I think that what we are seeing are two trends, and maybe those are related to what has gone on at the local level in the past.

I think, on the one hand, we are seeing a real development of programs with a broad view of advocacy and the role of legal services in a broad advocacy effort. And I think those programs are exemplified by Evergreen Legal Services in Washington. I think that such a broad approach comes out of a long history and a significant level of funding that allows the legal program—working with the area agencies, with other service providers, with other advocacy groups—to identify issues that are most important and then to focus their energies on those issues. In these situations, the types of cases handled tend to be public benefits, defending against guardianships, protecting rights of those in nursing homes and board and care homes, and so forth.

I think the other trend occurs in areas that have not had programs in the past and have not had good success and seen results from legal services. The trend in these areas is to fund private attorneys, usually solo practitioners, and to fund just a small portion of that individual's time. What that means is that the attorney is going to take what "walks through the door" for the most part. These private attorneys do not have the resources, the time, or the support to do much outreach or community education. Most do not have the capacity to identify issues to be targeted and work with all the other non-legal service providers so that they can make appropriate referrals. This means that what walks through the door are the people who know they need a will or they need a durable power of attorney; and these are the types of cases that are handled.

So I think we are seeing two trends; but the trend toward contracting with the private practitioner and getting a small portion of an attorney's time as opposed to a program is a significant one, and one about which I believe we need to be concerned.

Ms. **Fisher**. Let me emphasize something that Penny just said. In the last 10 years, we have seen—we do an annual update of who the Title III legal services providers are, and in the legal services providers in the last 10 years, we have gone from seeing almost 75 percent of those being legal services corporation grantees to now seeing something like close to 50 percent, not of total dollars spent but of providers coftracted with, being private attorneys.

It's a phenoeenal number, and, if that coftract, afd when we lgoked at thas three years, in those contracts, it as ngt specified what the services are that are to be prgvided, but they are based on number of hours of service, so that if Eli wanted to hang out a shingle in Norbeth and say, okay, you're going to contract with me for $5,000, he could charge $75 for a will, he could charge $25 for a will, he could charge $150 for doing a Social Security hearing.

There is not a standard set for that, so, again, you have a problem in terms of who is the provider, what are the services that they're being provided, and a real shift from the publicly funded legal services program being the Title III grantee to having it be a private attorney.

Ms. O'SHAUGHNESSY. Thank you.

We're rapidly approaching the close. Dr. Cohen has one comment, and the lady in the blue has had her hand up, so we'll take her question probably as the last question.

Mr. COHEN. Something that Elma Holder said I think bears some emphasis, and it has to do with whether you rely on people walking through the door with a complaint, which is very much in line with what I call a claim-based society. Nobody comes out and does something until you make a claim. The other part of it is that nonlawyers may see a problem, and it isn't important whether they identify it as a legal problem.

We shouldn't expect consumers to always identify the legal problem. It bothers me that there are people from health departments and welfare departments going out on quality of care teams and so on that see and know there's something wrong when somebody who wants to leave the nursing home can't, when somebody can't get to the telephone and can't use it.

Now, we ought to get some mechanisms to talk to folks, to say what do you see that bothers you, and let's see if there's a legal problem, and then try to bring in lawyers and say, hey, what's the approach on this? Are we going to do it, as Mr. Chiplin suggests, maybe we've got a private cause of action here, or maybe we're going to say, gee, we've got a real problem, but we have to get a private Attorney General statute put through, because this department or that department isn't doing what they ought to, or, you know, some other mechanism.

But we have to do more by way of making that connection from the folks who have been involved with the coalition for nursing home reform and who have been accumulating this kind of information and who know how to elicit what people sense as a problem, what they don't like, what they feel uncomfortable with, and start to bring some of the creative legal service attorneys into some kind of jointure with them so we can start to bring some remedies where they're appropriate through law.

Ms. O'SHAUGHNESSY. Thank you.

The lady in blue has a question.

Ms. HARDEN. Like most of your speakers, I have a comment rather than a question.

Ms. O'SHAUGHNESSY. Would you just give your name and your organization?

STATEMENT OF JANE HARDEN, LEGAL COUNCIL FOR THE ELDERLY, AARP

Ms. HARDEN. Yes. My name is Jane Harden. I'm with Legal Council for the Elderly of AARP. In response to your comment about lay advocates, we have done a survey and found that the great need of elderly people was for help with Medicare bills, and frequently Medicare bills are seen as being fact intensive bureaucratic problems, social problems, not good cases or easy cases for legal services lawyers to handle.

We have a pilot project in Pennsylvania and a project in the District of Columbia where trained lay advocates work with the elderly people, and then their cases are reviewed by the attorney to see which cases have legal aspects, which can be appealed, which reveal systemic problems that should be subject to legislative reform.

We are also looking into the issue of what you were talking about, lay advocates who work without legal supervision, to see if they would be interested in tighter links with legal services programs. We're also having a conference on this in the fall, and I can assure you I'll be in touch with you about it.

Ms. O'SHAUGHNESSY. Thank you.

John Monahan from the Senate Special Committee on Aging has a comment about the survey.

Mr. MONAHAN. Thank you. I just want to clarify how the survey was done. We did send out the survey to each of the 50 State offices and asked questions about the Title III services within those States. Now, we were fortunate in that many of the State offices then went on and relied not only on the data that they had collected but also went out and contacted some of the programs. So, of course, we didn't contact every single Title III legal services provider, but, hopefully, we're getting a pretty good cross section of how the money is spent.

I've only gotten responses so far from 29 States, but if you want any more detailed information, you'll find in your blue packet there's a three- or four-page summary sheet, including a copy of the questionnaire that went out to the State offices, but just so there's no confusion between all the different comments about what the survey meant and who it went to, I just thought I'd clarify that. Thanks.

Ms. O'SHAUGHNESSY. Arnie will probably have the last word since we have passed our time.

Arnie.

Mr. WHEDBEE. Thank you. I just want to make a couple of comments about lay advocates and the issue that Bill brought up. First of all, for example, we have worked in Washington State for 10 years with the case management system, which started out as information and assistance—a lot of information, very little assistance—to a case management program, which we have trained how to calculate the medically needy spend-down, how to do Medicare billing, and we think that Title III(b) dollars don't need to be spent on that particular activity.

But I think it has a lot to do with what you decide you're going to fund. If you want representation for those people who are, in terms of our ombudsman program, tied up in adult family homes from morning until night, they don't want a lay advocate, and they don't want a hotline. If their rights are going to be protected, there are going to be some people on the other side that are represented by attorneys and are very well represented.

If any laws are going to be changed in that area in the legislature, those people are going to be represented by a lot of lobbyists, and they're going to need more than a lay advocate. I don't have any problem with lay advocates, and I suppose if there's a State where there isn't a private attorney or a legal services funded outfit that will do any of this, maybe giving the money to the lay advocate to do Medicare bills would be better than nothing. So I think that you need to define what the needs are. Thanks.

Ms. O'Shaughnessy. I have a question on the means test conflict that was brought out I think by either David or Arnie, but I'll have to wait until the next session that the Senate committee has.

I think it's real exciting that we've gone overtime. There are so many questions and so many comments, people obviously feel very deeply and have a lot of information they want to share about legal services, both legal services and ombudsmen.

I'd like at this point to thank the panel and Dr. Cohen, very much. I think they did a super job. [Applause.]

Ms. O'Shaughnessy. And at this point, I guess the session will be closed. Thank you very much for coming, and thank you for your participation.

[Whereupon, the workshop was adjourned.]

APPENDIX

CAPACITIES OF THE STATE LONG-TERM CARE OMBUDSMAN PROGRAMS

A Report Presented to

The Special Committee on Aging

United States Senate

One Hundred First Congress

Prepared by

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June 28, 1990

EXECUTIVE SUMMARY

Residents of America's nursing homes and board and care homes are served unequally by ombudsman programs from state to state. In 84 percent of the states, a resident cannot expect to have an ombudsman in his/her facility more than once a month. Indeed, most residents in many states have never seen an ombudsman; they never will unless they go out of their way to file a complaint.

Although Title III of the Older Americans Act requires states to establish effective Long-Term Care Ombudsman Programs and to fund them adequately, neither the Act nor the regulations of the Administration on Aging provide an operational definition of effectiveness, adequate funding or staffing.

Federal funds are distributed to the states according to a formula that does not correspond to the number of clients served by the various offices of the State Ombudsman. As a result of the use of this formula, while most states receive between $100 and $150 per long-term care facility bed, four receive less than $90 and seven receive over $200.

States spend between $2.09 and $68.05 per bed, with most states spending in the $8 to $15 range. Funding levels are determined through diverse processes; there is no consensus within the states on a definition of "adequate funding."

Staffing levels also vary widely. The average state employs one full-time equivalent (FTE) per 3215 beds; the range of FTEs per bed is 789 to 21,500.

Most State Ombudsmen perceive that their capacities to recognize and remedy problems are severely limited by fiscal and personnel constraints. Few states (16%) average more than one visit per month to their facilities for purposes of becoming acquainted with residents, monitoring their care, and informing them of the program's services. Board and care homes are visited with considerably less frequency. More than half of the states report no routine visits to board and care homes. Fewer than 30 percent of the states have an ombudsman within a one-hour commute of all facilities.

Consideration should be given to legislative and/or regulatory reform which:

- funds ombudsman services independently of other services funded under Title III-B.
- allots ombudsman program funds to the states based upon factors that directly relate to the responsibility of the various state programs, as defined in the Act.
- defines staffing levels in such a way as to provide for the three essential human resource elements of the ombudsman program:
  - --professional service;
  - --volunteer service; and
  - --professional support of volunteers.
- defines and requires appropriate levels of federal, state and local funding.
- mandates equality of services in all areas of each state.

INTRODUCTION

The capacities of Long-Term Care Ombudsman Programs may be measured by certain factors which are accepted by most ombudsmen. These include:

- o to be known and accessed by residents, their representatives and other concerned citizens;
- o to respond rapidly to complaints and requests for assistance;
- o to use a broad number of strategies to remedy situations that impact residents negatively;
- o to inform the public of the standards of high quality care and of failures of providers to meet such standards;
- o to work effectively for improvements in services; and
- o to work effectively for improvement in the statutory and administrative laws that govern and fund such services.

The following is an analysis of expenditures and staffing patterns in states which voluntarily reported their data in response to questionnaires from the National Association of State Long-Term Care Ombudsman Programs (NASOP). (See Appendix B) It is presented in order to bring some quantitative information to bear upon the question of adequate funding of ombudsman programs.

In this paper we first attempt to describe the funding sources and variations between the states in funding. We then analyze the use of staff and the coverage of facilities. Finally, we suggest changes in the Older Americans Act to improve the capacity of state ombudsman programs to perform their functions.

FUNDING

The Older Americans Act

Title III

Beginning with its amendments of 1978, the Older Americans Act has required states, as part of Title III, to provide ombudsman services. Title III mentions in its General Provisions such services as nutrition and senior centers and explicates goals which are widely interpreted as emphasizing maintaining older Americans in their own homes and communities, namely:

> "(1) secure and maintain maximum independence and dignity in a home environment for older individuals capable of self care and with appropriate supportive services;
>
> (2) remove individual and social barriers to economic and personal independence for older individuals; and
>
> (3) provide a continuum of care for the vulnerable elderly." (Sec. 301 [a], 1978)

Ombudsman Funding Provisions

The major funding source for state ombudsman programs has been Title III-B of the Older Americans Act. From 1978 until 1987 the Act mandated that State agencies "use an amount equal to an amount not less than 1 percent of (its Title III-B allotment) or $20,000, whichever is greater, for the purpose of carrying out (the ombudsman function)." States could use state or local funds to satisfy this provision.

In 1987 this requirement was amended to provide that states allocate "such amount . . . as the State agency determines to be adequate for conducting an effective ombudsman program . . . ." (Sec. 304 [d][1][B])

Furthermore, "The State plan shall provide that the State agency . . . shall expend to carry out (ombudsman functions), for each fiscal year in which the allotment for part B for the State is not less than the allotment for fiscal year 1987 for part B for each State, an amount which is not less than the amount expended from funds received under this Act by such State in fiscal year 1987 to carry out (ombudsman functions)." (Sec. 307 [a][21])

Distribution to the States

The Title III-B funds are allotted to states through a formula that uses the ratio of population over age 60 as its basis (Sec. 304 [a][1]). For many states, however, there is no correlation between the number of Title III-B dollars and the number of beds served by ombudsman programs. As a result, there is a broad variation between the value of the funds allotted to the states by this formula and the magnitude of the responsibility of ombudsman programs. Alaska receives $616 per bed, while South Carolina, Washington State, Oregon and Iowa receive less than $90 per bed. [1]

Other Funding Sources

States fund their ombudsman services largely (62.5%) by use of Title III-B Services funds. (See Table Two)

As indicated in Table Three, the average Title III-B state allocation for ombudsman services is 5.3 percent of the Title III-B Service funds received by the state. Massachusetts spends the highest proportion of its Title III funds for the program (21.99%). New Jersey has elected to fund its program entirely with state monies. All but two states supplement these dollars with other Older Americans Act funds (usually Title IV and V) and/or with state funds, thus raising the average expenditure to 8.8 percent of the level of Title III-B allocations.

The past year has seen more activity in raising state sources for ombudsman efforts. Notable examples are:

- Texas, where the legislature approved a one-year expenditure of $100,000 for activities related to the implementation of OBRA;
- Washington, whose legislature added $175,000 to the ombudsman budget. This amount, which more than doubles the statewide budget over its 1988-89 level, is slated to be used for additional regional programs and for legal services to residents; and
- Ohio, which will tax long-term care facilities $3 per bed. This tax should add over $300,000 (36%) to the funds used to operate regional ombudsman programs.

Funding of Substate Programs

Thirty-one states reported having substate programs. These may be operated through contracts with Area Agencies on Aging or other service providers. Additional states have regional offices of the State office, but did not consider such offices to be "substate programs."

States have individual methods for funding local programs. Some allow discretion by the AAAs. These states may require an "adequate amount," set a minimum base, plus an amount per bed, or set a minimum "per bed per year." Under a "minimum-funding" policy, local agencies have a serious influence on the amounts that are expended statewide. Local agencies that aggressively pursue ombudsman services may elevate a state's expenditures; those allowed to spend small amounts may provide fewer services and will reduce the state's expenditure levels.

Other states are more prescriptive, allocating to the AAAs an amount from a statewide general ombudsman fund. The following are examples from states with high rates of coverage of their facilities (see discussion below).

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[1] We used the number of beds in the State's inventory of nursing home, board and care and other long-term care facilities, rather than the number of facilities, as a basis for comparing expenditures. Although the number of facilities served affects the use of program resources and is a useful unit of measurement, facilities range in size from three-bed board and care homes to 400-bed nursing facilities. We recommend that future considerations of funding levels determine the relative value of numbers of facilities and numbers of beds, as well as of geographic density, to measure the responsibility of ombudsman programs.

- Massachusetts' State Office establishes professional staffing patterns and salary levels for substate employees. The substate entities submit budgets for approval of the State Office.
- Oklahoma's State Office sets staffing levels. Area agencies in Oklahoma submit budgets for State Office review as part of the area plan.
- California's legislature has provided a formula. It includes a base amount, plus funds determined by the number of facilities, the number of beds and the number of square miles in the service area.
- Mississippi mandates that all area agencies operate programs. Agencies submit budgets, which are reviewed and must be approved by the State Office, as part of their area plans.
- Louisiana in FY 1990 abandoned its system that required $5 per bed minimum funding. It had been observed that the average AAA was spending over $9, while a few were spending no more than the $5. Three years of experience had shown that $5 per bed was inadequate, even when a large number of volunteers was employed. Louisiana now sets a base amount of $1800 (for agencies with only one nursing home within their Planning and Service Area), then uses numbers of beds and density of facilities to calculate the amount that is allotted by the State Unit. AAAs submit budgets for approval. They may add local or other Title III-B Service funds, but they must spend within the approved budget categories.

Comparison of expenditures

Most states spend between $8 and $15 per bed, with an average expenditure of $11.15, to fund their programs. Iowa and Washington State spend $2.09 and $2.88, respectively, while Washington, D.C. and Alaska--both serving few beds--spend $68.05 and $55.23 respectively.

Intrastate variation of funding cannot be explained by invoking economy of scale as a model. While 8 states with low inventories show above average costs, and 7 with high inventories show below average costs, 10 states with below average inventories show the lowest per-bed expenditures. (See Chart One.)

There is some correlation between the amount of Title III-B funding and ombudsman funding, as seen in Table Three. However, even when state and local funds are included in the total, Iowa, Florida, Kansas, Montana, Nebraska, Rhode Island, South Dakota and Washington spend less than 5 percent of the amount of their Title III-B allocations for ombudsman services. Arizona and Montana, which receive over $210 per bed in Title III-B, spend, respectively, the equivalent of 5.11 and 2.58 percent of their Title III-B allotments for their programs. On the other hand, New Jersey and Minnesota, receiving less than $100 per bed, spend 14.46 and 14.83 percent.

CHART ONE

EXPENDITURES COMPARED WITH BED INVENTORIES

BEDS	EXPENDITURES PER BED (ALL SOURCES)				
	<$5	$5-10	$10-20	$20-30	>30
>70,000	1	6	2		
50,000 - 70,000	1	2	2		1
30,000 - 50,000	2	2	4	1	
10,000 - 30,000	1	3	4	2	
<10,000	1	1	2	3	4

Some variation may result from differences in the way states budget for certain activities that support the ombudsman program. Training, public relations, printing, and monitoring may or may not be charged to the ombudsman budget, thus distorting the comparison.

Discussion

It is obvious that the provision of the Act that states allocate funds "adequately" in order to provide an "effective ombudsman program" has been interpreted variously by the states. Certain portions of the Act may have contributed to this variation.

First, although the General Provisions of Title III do not specifically exclude services to residents of nursing homes and board and care homes, they carry a connotation which has been widely interpreted within some State and Area agencies as dealing with residents in the community and in their traditional family homes. Since 1978 the opinion has been persistently expressed that the ombudsman program dilutes the funds available for OAA agencies to "serve those the Act was intended to serve."

Second, the allotment formula provided within the Act has not taken into account the responsibilities of ombudsman programs. The number of residents to be served by ombudsmen is not directly related to the number of individuals over 60 in the states. Consequently, states have reached their funding levels by a variety of avenues. Some states have intentionally set expenditures; others have arrived at them by less controlled methods.

This variation is reflected in another measure of capacity: staffing and coverage of all facilities.

STAFFING

Professional Staff

By its legal and technical nature, ombudsman work demands a high level of expertise and consistency. Although volunteers are valued for their excellent and widespread services in many states, professional staff are needed for training, supervision and support. If volunteers are to be recruited from the current workforce, training will have to be available at their convenience. They will need professionals who are available regularly for advice, consultation and referral. Consequently, the number of paid staff is an important measure of the program's capacity.

Table Four displays the number of paid ombudsman staff per state in terms of Full-Time Equivalents (FTE). The average number of FTEs nationwide is 13.6 FTEs per state (one per 3215 beds). Approximately 20 percent of these employee-hours are used in the Office of the State Ombudsman. Variation is sufficiently great, however, to render an average misleading. The rates of FTEs per bed ranges from 789 to 21,500. New Jersey houses all 14 of its staff at the Office, for example, while other states show a high ratio of substate employees to State Office employees (Mississippi, 1:18; California, 1:16; Illinois, 1:14; and Louisiana, 1:12).

It should be noted that staffing is usually, but not always, a function of funding levels. Some states have experienced hiring freezes such that, were monies for an additional staff member at the State Unit available, they could not be spent there for personnel. In such cases, it may be easier to build substate programs than State Office support.

Use of Staff Time

Table Five displays State Ombudsmen's estimates of the allocation of time by State Office employees.

Not surprisingly, where there are fewer substate programs and personnel, State Office ombudsmen are called upon more often to deal with individual cases. States with large substate programs often allocate high levels of time to administration and training.

Although most State units are totally given to long-term care advocacy issues, some spend time in other work. Connecticut, which considered its work load unique, did not report all activities. However, the State Ombudsman estimates that her office staff spends over two-thirds of its time in adult protection activities. In Arizona and West Virginia, state unit employees use about 20 percent of their time in non-ombudsman activities.

COVERAGE

Most State Ombudsmen report that they cover all facilities in the state. By "100% coverage" they often mean that all facilities are assigned an ombudsman or that a resident from any facility may receive the services of an ombudsman.

Routine Visits

If coverage is defined in terms of the number of times a facility is visited by an ombudsman in a year a more accurate picture is seen.

For purposes of measurement of coverage we used the weekly visit by an authorized ombudsman as the highest standard. We asked how many facilities receive a "routine" visit within given time periods. (A "routine visit" is defined as one in which an ombudsman visits residents to get to know them and their needs, to make them aware of the program and of the means of accessing the services of an ombudsman and to monitor their care and the conditions in the facility.) We also asked whether the State had a standard frequency of visits and what that standard is. These visits and standards are displayed on Table Six.[2]

Thirty-one of 44 reporting states have a standard frequency of visits to nursing homes; 26 have standards for board and care visits. As seen in Table Seven, eleven states strive to make a routine visit to all nursing facilities each week; seven to visit all board and care facilities weekly. Six attempt annual nursing facility visits; seven have a board and care standard of once a year.

TABLE SEVEN

STANDARDS OF ROUTINE VISITS

	Nursing Facilities	Board and Care
Annual	6	7
Bi-annual	1	1
Quarterly	4	5
Monthly	8	6
Bi-weekly	1	1
Weekly or more	11	7

Few state programs actually meet their standards, however. If a weekly visit is given a score of 100 and no routine visits is scored "0," only Massachusetts scores 100. Remarkably, only seven (16%) states achieve a score of 50 or above (ie. routine visit at least once a month).

Five states score 50 or better in coverage of board and care homes. More than 50 percent of the states make no routine visits to board and care homes.

Proximity of Ombudsmen

Coverage of long-term care facilities may also be defined in terms of proximity of an authorized ombudsman to the facilities. Geographical closeness is important not only because it enables ombudsmen to spend more time investigating and resolving problems, but also because it places ombudsmen within telephone reach of residents and concerned individuals. We chose as a standard measure of proximity a one-hour commute time.

As seen in Table Six, only 13 of 44 states have an authorized ombudsman--paid or volunteer--within an hour's commute of all facilities. Thirty-three have an ombudsman within a one-hour commute of 50 percent or more facilities.

Summary: the Cost of Coverage

Monetary costs. Expenditures for high coverage by means of routine visits range from $9.61 per bed (Texas) to $68.05 (District of Columbia). States in which ombudsmen visit nursing homes at least monthly spend an average of $24.47 per bed. The average cost per bed of having an ombudsman within a one-hour commute of all facilities is $17.43, with a range of $4.51 to $68.05.

Non-financial costs. Dollars are not the sole costs of emphasizing routine visits and proximity, however. If funding is limited, emphasis on providing routine visits erodes resources from such other important areas as case review, public education and systems advocacy. State Ombudsmen in some of the programs with high coverage and relatively low unit costs recognize the need to improve quality and add dimensions of service:

- Oklahoma, with a cost of $13.49 and a routine visit score of slightly more than once a month, finds the staffs of at least three local programs overloaded with complaints. The State Ombudsman also wants more staff time to provide more preventive services and sees a need to increase salaries in order to slow the rate of local staff turnover.

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[2] "Service" indicates work on individual cases; "Systems" indicates work related to cases and issues that affect more than one resident; "Admin." indicates administrative duties; "Public" indicates public education efforts and "Non-Omb." indicates activities not specified in the scope of work as laid out in the Act. Such activities include guardianships and adult protective services.

- Louisiana, which has a cost of $14.50 and ombudsmen close to all facilities, reports that some local ombudsmen, who work as ombudsmen as part of their jobs in Area Agencies and parish agencies, visit facilities but have never or seldom reported a complaint. With a limited number of staff in the State office, no regional workers and 31 substate programs, there is no time for the sort of in-depth evaluation, case-review and technical assistance that promotes high quality casework.

- Texas, likewise, finds quality of investigations limited by the very factors that promote high coverage: too many local workers are part-time ombudsmen, sharing their time with other agency duties. Program development, volunteer recruitment, supervision and monitoring suffer. Texas spends $9.61 per bed.

PERCEIVED NEEDS

Program Limits

Ombudsmen appear to give regular presence in facilities their highest priority when assessing the results of fiscal limitations of their programs. When given a list of seven service areas and asked to indicate in which of these areas they considered their programs to be limited by a lack of funding, virtually all respondents (89%) indicated that they felt limited in their availability to residents on a regular basis, that is to have program personnel present in facilities for the purpose of getting to know residents and their needs, as opposed to reacting to complaints only.

Their second and third priorities relate to development of staff and volunteers: 64 percent lack adequate capacity to manage volunteers; 57 percent consider themselves lacking in capacity to train staff and volunteers. Table Eight displays the responses.

TABLE EIGHT

AREAS IN WHICH STATE OMBUDSMEN CONSIDER PROGRAMS TO BE LIMITED DUE TO LACK OF FUNDING

PER CENT OF RESPONSES	SERVICE AREA LIMITED
89	Availability to residents regularly
64	Volunteer management
57	Training of staff and volunteers
55	Pursuit of legal remedies
55	Rapid response to complaints
43	High-quality investigations
41	Public education (media, printing)

Write-in responses: Systems advocacy, 7 percent; Data collection from Ombudsmen and other agencies, 2 percent; Insurance for volunteers, 2 percent.

Proposed Objectives

Ombudsmen were also asked to list as many as three objectives which they would attempt to meet if additional funds were available. Respondents provided a wide array of answers. (See Appendix A.) Most respondents targeted the imaginary new dollars at improvement of regional and other substate programs. However, states with large numbers of substate programs and personnel (both staff and volunteer) noted needs to add to the State Office staff. Legal assistance, training capacity and public education programs also received a large number of comments.

ESTIMATES OF ADEQUATE ALLOCATIONS

Although the NASOP survey incorporated in the present study has not developed sufficient data to substantiate a precise estimate of the costs of operating an effective State ombudsman program, we will offer a few observations which are designed to advance the discussion of how to define the term "adequate funding" in policy.[3]

Base funding.

An equitable formula would take into account the base costs required to operate any program as discrete and independent as an Ombudsman program. If states with small numbers of beds (under 10,000) are considered as a group, the average cost is $146,396.

However, only two of these provide coverage at the level of more than once a month. Their costs, coverage scores and number of facilities with an ombudsman within a one-hour commute are shown below:

State	Total Costs	Cost/Bed	Coverage N.H.	B.C.	Prox.
Dist. Col.	$356,085	$68.05	96	27	100
New Mexico	$172,439	$22.58	50	10	50

It appears that a base cost for "adequate" operation is approximately $300,000.

A review of Table Six permits selection of four states (Louisiana, Massachussets, Texas and California) with more than 30,000 beds and coverage scores of over 75. Their average cost per bed is $17.55. Some economy of scale is evident in this group; states with higher number of beds show the lower rates.

It appears that no less than Texas' $9.61 per bed can be considered. Even then, Texas and California lack weekly coverage of all of their facilities and only 30 and 60 percent of their facilities, respectively, have a paid ombudsman within a one hour commute.

If regional cost of living differentials and economies of scale are allowed, it would appear that programs in states of over 10,000 beds should spend between $14 and $35 per bed.

CONCLUSION

Federal policies governing the offices of the State Ombudsman have advanced considerably over the twelve years of the national mandate. Definitions of legal responsibilities, protections, and rights of ombudsmen have been enhanced.

Provisions that guide states in determining levels of funding and staffing do not appear to have been among those areas in which the Act has been improved, however. Based upon reports of spending and staffing from FY 1989, the states have widely varying interpretations of what an "effective" ombudsman program is, how much an effective program costs and what "adequate" funding is. (Some states report improvements in FY 1990; others are planned for FY 1991. However, other states indicate no significant change in either area.)

This imprecision in policy has led to a disparity between states in the Ombudsman services that a resident can expect to receive. In 84 percent of the states, a resident cannot expect to have an ombudsman in his/her facility more than once a month. Indeed, most residents in many of the nation's facilities have never seen an ombudsman; they never will if they do not go out of their way to file a complaint.

Clearly, the experience of the past twelve years calls for more definitive statutory and administrative legislation regarding funding and staffing.

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[3] Within the following discussion it is assumed that weekly visitation of residents is minimal for adequate coverage.

Consideration should be given to legislative and/or regulatory reform which:

- funds ombudsman services independently of other services funded under Title III-B.
- allots ombudsman program funds to the states based upon factors that directly relate to the responsibility of the various state programs, as defined in the Act.
- defines staffing levels in such a way as to provide for the three essential human resource elements of the ombudsman program:
  --professional service;
  --volunteer service; and
  --professional support of volunteers.
- defines and requires appropriate levels of federal, state and local funding.
- mandates equality of services in all areas of each state.

APPENDIX A

"IF FUNDS WERE AVAILABLE"

RESPONSES TO THE REQUEST FOR PROPOSED OBJECTIVES

Regional Staff

Regional staff for supervision, problem solving and routine coverage.(11)

Increase salaries for regional ombudsmen for superior skills, knowledge and retention. (5)

Sub-state part-time positions would be elevated to full-time.(5)

Convert the 2 district coordinator contract positions to permanent employees. This would provide more stability and continuity as we experience a lot of turnover under the present arrangement.

Increase funding levels to the sub-state programs to enable them to hire more staff for direct services and the training and monitoring volunteers.

Local Staff

Hire additional investigative field personnel so that the Ombudsman Office would be available to residents on a continual basis. (7)

Ensure that all sub-state programs had an assistant director, expand the coverage in large programs to a full-time assistant director.

Provide for more stipended/paid visiting ombudsmen on local level to offer stability. (2)

Provide each local program with a full-time volunteer coordinator to recruit, train and supervise volunteers.

Increase staffing in the local programs, due to increasing number of facilities and beds and high activity on complaints.

Focus some of additional staff time on volunteer management, to provide more preventive services. (3)

Hire local ombudsman directly. Receive legal help on policy analysis, legal issues.

Additional staff in each of the six sub-state programs to focus on community based complaints.

Paid ombudsmen to work full-time in assigned facilities where volunteers have been difficult to recruit.

Hire 4 full-time staff to begin a volunteer program.

Include a trained volunteer component in all sub-state programs.

State Office Additional Staff

Staff at SUA for supervision and problem solving. (4)

Additional staff for board and care complaint investigation and advocacy.(2)

Hire at least one more person to assist State Ombudsman in the development of legislative and policy initiatives on long-term health care.

Employ 1 full-time employee or 2 part-time employees to recruit, train, support volunteers to work at the 5 sub-state programs visiting facilities and assisting with complaints, casework, presentations, etc.

Hire one additional ombudsman at state office to manage the complaint response system, principally to allow other 2 state staff to provide better support to local staff (via training and materials) and to move more pro-actively with regard to the enforcement/ regulatory/reimbursement system. When staffing is short, complaints always take priority over "systems" work.

Hire staff to write policies and procedures for implementation state-wide.

State level residential long term care policy analysis and advocacy.

Additional staff to develop a comprehensive volunteer program including recruiting, training and work toward retaining volunteer pool.

Another ombudsman to be able to provide adequate response to resident complaints and problems. (At this time we are forced to triage and some case resolution is delayed.)

Expand state unit staff to coordinate a statewide volunteer ombudsman program.

Legal Assistance

Additional staff to recruit and train lawyers to take nursing home and board and care cases.

Retain or hire legal counsel to provide technical assistance on complex cases.

Hire an attorney consultant to work in specific legal issues (i.e. nursing home admission contracts).

Acquire dedicated legal representatives to work on a day-to-day basis with state programs, especially in guardianship and administrative hearings areas.

Legal Representation - we need it, don't have it and can't afford it!

Clerical and Computer

Hire clerical/administrative support staff. (2)

Centralized intake procedure and have someone coordinate the assignment of complaints as well as regular office duties.

Develop system of computer modems to record and transmit the required reports from local programs to the State Office.

Hire secretary/clerk to handle computer and other office functions. (3)

Purchase computer or implement an improved MIS and sub-state performance monitoring system. (3)

Hire a systems manager to manage the flow and protection of all complaint records, handle all computerization of records, provide statistical and other summary reports, and track fiscal information on sub-contract billing and reimbursement.

Training

Staff at SUA for training. (14)

I would hire a volunteer coordinator/trainer at the State Office to assure that all volunteer ombudsmen received uniform, consistent training. (5)

Contract some of the ombudsman training and hire experts to provide educational sessions.

Additional training on a quarterly basis for professional ombudsmen to increase their knowledge of issues surrounding entitlement systems, long term care, complaint handling and program management.

Public Education

Update and develop more educational literature and videos that could be disseminated throughout the state. (11)

I would publicize the program more and reach more people.

Increase public awareness on legislative issues.

Develop and implement public education programs on a number of long term care issues for families, residents and the community in general.

Other

More travel to conduct investigations instead of using the telephone.

Staff to focus on home care complaints.

Provide funds to local programs to reimburse volunteers for travel, training, telephone calls and stipends if needed to cover their services to the program. (2)

Supplement travel budgets at the sub-state level to increase routine visits to all long term care facilities.

Spanish speaking staff in the three PSA's with high concentrations of Hispanic elderly.

Develop a citizen advocacy network connected with but independent of the LTCOP.

APPENDIX B

NOTES ON THIS REPORT

Method

The leadership of the National Association of Long-Term Care Ombudsmen (NASOP), appealed to the State Long-Term Care Ombudsmen to reply to two questionnaires. The first requested fiscal data from FY 1988-89 and inventories of long-term care beds served. Forty-six programs replied to this questionnaire.

The second questionnaire asked for information concerning the frequency of visits to facilities, the distance from facilities of ombudsmen who are "authorized" to investigate complaints, the number of paid "authorized" ombudsmen, the allocation of time by ombudsmen at the Office of the State Long-Term Care Ombudsman, the areas in which the State Ombudsman considers his/her capacity hampered by lack of funding, and the objectives which the State Office would give highest priority if additional funds were available. Forty-four programs replied to this questionnaire.

Following a preliminary analysis of the data reported on these questionnaires, the researchers conducted telephone interviews with State Ombudsmen of selected states showing high and low coverage of long-term care facilities.

Limitations

While we consider this report to be valueble in that it contains information that has not previously been compiled in this format, it should be considered preliminary to a more thoroughgoing evaluation of both the capacities and outcomes of Long-Term Care Ombudsman Programs nationwide, we recognize that its value is limited by its scope, the sources of its data and the constraints upon the researchers.

Scope. This report is a description of selected, key measures of capacity, not the effectiveness of the various programs. For example, some highly successful programs, laboring under financial constraints, have carefully used their limited resources to address issues that impact large numbers of residents. Their lack of routine coverage of their states' facilities should not be taken as a sign of ineffectivess.

Data. Due to the fact that research time was severely limited, as was ombudsman/respondents' time, we requested data from one year only. Furthermore, most states do not maintain records that capture the requested data in a format that is quickly retrieved, nor do they employ research evaluation staffs to prepare such information.

Research. Professional researchers were not available to carry out the project. Data were requested, compiled and analyzed over a nine-week period by two State Ombudsmen who carried out their work largely in their off-hours.

TABLE ONE

TITLE III-B ALLOTMENTS COMPARED WITH BED INVENTORY FY 1989

STATE	BEDS*	TITLE III-B (SUPPORT. SERV.) ALLOTMENTS**	III-B ALLOTMENT (SUPPORT. SERV.) PER BED
ALASKA	2,247	$1,383,200	$616
ARIZONA	16,035	$3,425,527	$214
ARKANSAS	19,000	$3,072,008	$162
CALIFORNIA	220,000	$25,559,872	$116
COLORADO	25,583	$2,694,418	$105
CONNECTICUT	32,166	$3,874,067	$120
DELAWARE	5,940	$1,402,436	$236
DIST.OF COL.	5,233	$1,402,615	$268
FLORIDA	123,162	$17,108,683	$139
GEORGIA	47,878	$5,433,179	$113
HAWAII	6,524	$1,430,727	$219
IDAHO	7,212	$1,425,287	$198
ILLINOIS	111,402	$12,770,263	$115
IOWA	43,000	$3,756,790	$87
KANSAS	29,083	$3,023,308	$104
KENTUCKY	31,465	$4,100,319	$130
LOUISIANA	35,953	$4,164,855	$116
MAINE	12,872	$1,473,238	$114
MARYLAND	29,317	$4,318,573	$147
MASSACHUSETTS	55,487	$7,231,001	$130
MICHIGAN	93,627	$9,500,077	$101
MINNESOTA	49,934	$4,711,263	$94
MISSISSIPPI	14,986	$2,868,719	$191
MISSOURI	53,295	$6,250,148	$117
MONTANA	6,500	$1,416,854	$218
NEBRASKA	21,117	$2,025,731	$96
NEVADA	4,774	$1,424,522	$298
NEW HAMPSHIRE	9,339	$1,434,052	$154
NEW JERSEY	100,000	$8,998,017	$90
NEW MEXICO	7,636	$1,430,121	$187
NEW YORK	135,703	$21,442,222	$158
N. CAROLINA	57,550	$6,444,222	$112
OHIO	103,000	$12,077,344	$117
OKLAHOMA	32,614	$3,740,010	$115
OREGON	27,328	$3,145,840	$115
PENNSYLVANIA	100,710	$15,732,839	$156
RHODE ISLAND	10,331	$1,450,122	$140
S. CAROLINA	39,658	$3,178,221	$80
S. DAKOTA	8,457	$1,415,761	$167
TENNESSEE	39,194	$5,247,673	$134
TEXAS	113,543	$14,275,114	$126
VERMONT	5,980	$1,392,443	$233
VIRGINIA	50,353	$5,444,244	$108
WASHINGTON	53,420	$4,553,989	$85
WEST VIRGINIA	15,000	$2,442,202	$163
WISCONSIN	53,476	$5,587,797	$104

*Includes all long-term care facilities covered by ombudsman program.

TABLE TWO

OMBUDSMAN PROGRAM FUNDING
DETAILED

STATE	BEDS*	FEDERAL FUNDS			STATE FUNDS	OTHER FUNDS	TOTAL FUNDING	PER BED
		OAA:III	OAA:OTHER	TOTAL OAA				
ALASKA	2,247	$76,400	$4,000	$80,400	$43,700	$0	$124,100	$55.23
ARIZONA	16,035	$75,594	$0	$75,594	$99,600	$0	$175,194	$10.93
ARKANSAS	19,000	$248,697	$0	$248,697	$5,432	$0	$254,129	$13.38
CALIFORNIA	220,000	$1,136,315	$0	$1,136,315	$1,634,729	$0	$2,771,044	$12.60
COLORADO	25,583	$333,969	$0	$333,969	$2,605	$0	$336,574	$13.16
CONNECTICUT***	32,166	$88,020	$0	$88,020	$92,230	$0	$180,250	$5.60
DELAWARE	5,940	$88,000	$0	$88,000	$35,037	$0	$123,037	$20.71
DIST.OF COL.	5,233	$44,458	$25,000	$69,458	$140,162	$146,465	$356,085	$68.05
FLORIDA	123,162	$437,467	$0	$437,467	$43,287	$0	$480,754	$3.90
GEORGIA	47,878	$873,650	$0	$873,650	$68,450	$85,724	$1,027,823	$21.47
HAWAII	6,524	$32,000	$0	$32,000	$60,000	$0	$92,000	$14.10
IDAHO	7,212	$197,066	$30,100	$227,166	$16,000	$0	$243,166	$33.72
ILLINOIS	111,402	$703,853	$120,464	$824,317	N/A	$118,584	$942,901	$8.46
IOWA	43,000	$90,012	$0	$90,012	$0	$0	$90,012	$2.09
KANSAS	29,083	$124,277	$0	$124,277	$4,827	$4,132	$133,236	$4.58
KENTUCKY	31,465	$266,851	$0	$266,851	$89,483	$158,463	$514,797	$16.36
LOUISIANA	35,953	$368,867	$0	$368,867	$105,936	$46,409	$521,212	$14.50
MAINE	12,872	$50,917	$0	$50,917	$68,682	$0	$119,599	$9.29
MARYLAND	29,317	$125,000	$33,000	$158,000	$0	$149,482	$307,482	$10.49
MASSACHUSETTS	55,487	$1,590,049	$115,128	$1,705,177	$126,360	$25,774	$1,857,311	$33.47
MICHIGAN	93,627	$193,655	$8,194	$201,849	$444,705	$158,535	$805,089	$8.60
MINNESOTA	49,934	$490,311	$0	$490,311	$61,000	$147,157	$698,468	$13.99
MISSISSIPPI	14,986	$238,774	$34,253	$273,027	$15,805	$32,927	$321,759	$21.47
MISSOURI	53,295	$354,215	$0	$354,215	$54,210	$134,851	$543,276	$10.19
MONTANA	6,500	$20,000	$10,000	$30,000	$6,500	$0	$36,500	$5.62
NEBRASKA	21,117	$50,258	$20,324	$70,582	$1,662	$0	$72,244	$3.42
NEVADA	4,774	$40,000	$0	$40,000	$63,139	$0	$103,139	$21.60
NEW HAMPSHIRE	9,339	$89,653	$17,521	$107,174	$12,087	$0	$119,261	$12.77
NEW JERSEY	100,000	$0	$0	$0	$1,301,000	$0	$1,301,000	$13.01
NEW MEXICO	7,636	$134,044	$0	$134,044	$28,410	$9,985	$172,439	$22.58
NEW YORK	135,703	$971,772	$0	$971,772	$73,795	$281,141	$1,326,708	$9.78
NORTH CAROLINA	57,550	$490,908	$0	$490,908	$36,965	$89,834	$617,707	$10.73
OHIO	103,000	$592,627	$38,119	$630,746	$75,720	$146,015	$852,481	$8.28
OKLAHOMA	32,614	$294,432	$17,764	$312,376	$86,918	$40,530	$439,824	$13.49
OREGON	27,328	$56,500	$0	$56,500	$225,311	$114,561	$396,372	$14.50
PENNSYLVANIA	110,710	$733,727	$0	$733,727	$129,476	$101,698	$964,901	$8.72
RHODE ISLAND	10,331	$33,522	$0	$33,522	$27,808	$0	$61,330	$5.94
SOUTH CAROLINA*	39,658	$60,386	$0	$60,386	$110,656	$5,000	$176,042	$4.44
SOUTH DAKOTA	8,457	$32,427	$0	$32,427	$5,722	$0	$38,149	$4.51
TENNESSEE	39,196	$320,557	$0	$320,557	$0	$52,337	$372,894	$9.51
TEXAS	113,543	$995,145	$0	$995,145	$95,905	$0	$1,091,050	$9.61
VERMONT	5,980	$164,745	$24,000	$188,745	$1,950	$11,925	$202,620	$33.88
VIRGINIA	50,333	$150,211	$0	$150,211	$99,888	$96,090	$346,189	$6.88
WASHINGTON	53,420	$45,000	$0	$45,000	$89,000	$20,000	$154,000	$2.88
WEST VIRGINIA	15,000	$63,000	$0	$63,000	$308,733	$0	$371,733	$24.78
WISCONSIN	53,476	$63,000	$9,700	$72,700	$309,500	$0	$382,200	$7.15
TOTAL	2,054,715	$13,682,731	$507,547	$14,190,478	$6,661,541	$2,063,058	$22,915,076	$11.15

FEDERAL DOLLARS AS PERCENTAGE OF TOTAL FUNDING: 62.5%
SUBSTATE DOLLARS AS PERCENTAGE OF TOTAL FUNDING: 51.30%

* Includes nursing facility beds and all other beds served by Ombudsmen.

** Includes approx. $100,000 in salaries for 4 positions funded by Gov's Office from State funds

*** The Connecticut program attributes about 33% of its time to facility-based services, 67% to protective services. The "total funding" column is adjusted to reflect estimated expenditures for Ombudsman services as defined in the Older Americans Act.

TABLE THREE

TITLE III-B ALLOTMENTS
UTILIZED FOR OMBUDSMAN FUNDING
FY 1989

STATE	TITLE III-B (SUPPORT. SERV. ALLOTMENT**	OMBUDSMAN FUNDS FROM TITLE III-B	OMBUDSMAN FUNDS FROM TITLE III-B (PER CENT)	OMBUDSMAN FUNDS FROM ALL SOURCES	OMBUDSMAN FUNDS FROM ALL SOURCES (PER CENT OF III-B ALLOT.)
ALASKA	$1,383,200	$76,400	5.52%	$124,100	8.97%
ARIZONA	$3,425,527	$75,594	2.21%	$175,194	5.11%
ARKANSAS	$3,072,008	$248,697	8.10%	$254,129	8.27%
CALIFORNIA	$25,559,872	$1,136,315	4.45%	$2,771,044	10.84%
COLORADO	$2,694,418	$333,969	12.39%	$336,574	12.49%
CONNECTICUT	$3,874,067	$88,020	2.27%	$180,250	4.65%
DELAWARE	$1,402,436	$88,000	6.27%	$123,037	8.77%
DIST.OF COL.	$1,402,615	$44,458	3.17%	$356,085	25.39%
FLORIDA	$17,108,683	$437,467	2.56%	$480,754	2.81%
GEORGIA	$5,433,179	$873,650	16.08%	$1,027,823	18.92%
HAWAII	$1,430,727	$32,000	2.24%	$92,000	6.43%
IDAHO	$1,425,287	$197,066	13.83%	$243,166	17.06%
ILLINOIS	$12,770,263	$703,853	5.51%	$942,901	7.38%
IOWA	$3,756,790	$90,012	2.40%	$90,012	2.40%
KANSAS	$3,023,308	$124,277	4.11%	$133,236	4.41%
KENTUCKY	$4,100,319	$266,851	6.51%	$514,797	12.56%
LOUISIANA	$4,164,855	$368,867	8.86%	$521,212	12.51%
MAINE	$1,473,238	$50,917	3.46%	$119,599	8.12%
MARYLAND	$4,318,573	$125,000	2.89%	$307,482	7.12%
MASSACHUSETTS	$7,231,001	$1,590,049	21.99%	$1,857,311	25.69%
MICHIGAN	$9,500,077	$193,655	2.04%	$805,089	8.47%
MINNESOTA	$4,711,263	$490,311	10.41%	$698,468	14.83%
MISSISSIPPI	$2,868,719	$238,776	8.32%	$321,759	11.22%
MISSOURI	$6,250,148	$354,215	5.67%	$543,276	8.69%
MONTANA	$1,416,854	$20,000	1.41%	$36,500	2.58%
NEBRASKA	$2,025,731	$50,258	2.48%	$72,244	3.57%
NEVADA	$1,424,522	$40,000	2.81%	$103,139	7.24%
NEW HAMPSHIRE	$1,434,052	$89,653	6.25%	$119,261	8.32%
NEW JERSEY	$8,998,017	$0	0.00%	$1,301,000	14.46%
NEW MEXICO	$1,430,121	$134,044	9.37%	$172,439	12.06%
NEW YORK	$21,442,222	$971,772	4.53%	$1,326,708	6.19%
N. CAROLINA	$6,444,222	$490,908	7.62%	$617,707	9.59%
OHIO	$12,077,344	$592,627	4.91%	$852,481	7.06%
OKLAHOMA	$3,760,010	$294,432	7.83%	$439,824	11.76%
OREGON	$3,145,840	$56,500	1.80%	$396,372	12.60%
PENNSYLVANIA	$15,732,839	$733,727	4.66%	$964,901	6.13%
RHODE ISLAND	$1,450,122	$33,522	2.31%	$61,330	4.23%
S. CAROLINA	$3,178,221	$60,386	1.90%	$176,042	5.54%
S. DAKOTA	$1,415,761	$32,427	2.29%	$38,149	2.69%
TENNESSEE	$5,267,673	$320,557	6.11%	$372,896	7.11%
TEXAS	$14,275,116	$995,145	6.97%	$1,091,050	7.64%
VERMONT	$1,392,443	$164,765	11.83%	$202,620	14.55%
VIRGINIA	$5,444,264	$150,211	2.76%	$346,189	6.36%
WASHINGTON	$4,553,989	$45,000	0.99%	$154,000	3.38%
W. VIRGINIA	$2,442,282	$63,000	2.58%	$371,733	15.22%
WISCONSIN	$5,587,797	$63,000	1.13%	$382,200	6.84%
AVERAGE	$256,679,913	$13,630,331	5.31%	$22,618,081	8.81%

TABLE FOUR

		PROFESSIONAL STAFF		
STATE	BEDS	STATE LEVEL	(FTE) SUBSTATE LEVEL	FTE/BED RATIO
ALASKA	2,247	2.0	0.0	1123.50
ARIZONA	16,035	1.0	4.3	3025.47
ARKANSAS	19,000	1.0	8.8	1938.78
CALIFORNIA	220,000	6.0	95.0	2178.22
COLORADO	25,583	1.8	10.7	2054.86
DELAWARE	5,940	4.5	0.0	1320.00
DIST.OF COL.	5,233	3.0	3.0	872.17
FLORIDA	123,162	2.0	11.0	9474.00
GEORGIA	47,878	3.5	33.5	1294.00
HAWAII	6,524	1.0	0.0	6524.00
IDAHO	7,212	1.0	7.5	848.47
ILLINOIS	111,402	2.0	28.6	3640.59
IOWA	43,000	2.0	0.0	21500.00
KANSAS	29,083	3.0	1.0	7270.75
KENTUCKY	31,465	3.0	13.0	1966.56
LOUISIANA	35,953	1.5	17.5	1892.26
MAINE	12,872	3.0	0.0	4290.67
MARYLAND	29,317	1.0	7.0	3664.63
MASSACHUSETTS	55,487	5.0	33.0	1460.18
MICHIGAN	93,627	3.0	19.1	4236.52
MINNESOTA	49,934	1.5	12.9	3467.64
MISSISSIPPI	14,986	1.0	18.0	788.74
MISSOURI	53,295	1.0	9.7	4980.84
MONTANA	6,500	1.0	3.4	1477.27
NEBRASKA	21,117	1.6	1.0	8121.92
NEVADA	4,774	3.0	0.0	1591.33
NEW HAMPSHIRE	9,339	4.0	0.0	2334.75
NEW JERSEY	100,000	14.0	0.0	7142.86
NEW MEXICO	7,636	3.0	3.0	1272.67
NEW YORK	135,703	4.0	19.0	5900.13
OKLAHOMA	32,614	2.0	13.0	2174.27
RHODE ISLAND	10,331	2.0	2.5	2295.78
SOUTH CAROLINA**	39,658	4.0	3.0	5665.43
SOUTH DAKOTA	8,457	4.0	0.0	2114.25
TENNESSEE	39,124	1.0	9.0	3912.40
TEXAS	113,543	2.5	16.0	6137.46
VERMONT	5,980	1.0	6.0	854.29
VIRGINIA	50,353	2.0	5.9	6373.80
WASHINGTON	53,420	2.5	4.5	7631.43
WEST VIRGINIA	15,000	1.0	9.0	1500.00
WISCONSIN	53,476	8.0	0.0	6684.50
TOTAL	1,746,260	114.35	428.90	
AVERAGE	43,657	2.86	10.72	3214.47

TABLE FIVE

STATE UNIT TIME ALLOCATION
(PERCENT)

STATE	SERVICE	SYSTEMS	ADMIN	TRAINING	PUBLIC	NON-OMB
ALABAMA	10	15	30	25	15	5
ALASKA	75	5	5	10	5	0
ARIZONA	15	10	20	25	10	20
ARKANSAS	5	15	60	10	10	0
CALIFORNIA	10	25	35	15	10	5
COLORADO	32	28	11	17	10	2
DELAWARE	73	2	10	2	4	0
DIST.OF COL.	25	20	20	15	20	0
FLORIDA	5	30	40	15	10	0
GEORGIA	5	10	45	40	0	0
HAWAII	50	10	15	0	20	5
IDAHO	5	35	35	5	10	10
ILLINOIS	0	20	70	5	5	0
KANSAS	25	20	30	0	30	0
KENTUCKY	15	25	15	25	15	5
LOUISIANA	15	15	30	30	10	0
MAINE	55	20	10	5	10	0
MARYLAND	10	5	40	10	20	15
MASSACHUSETTS	10	30	35	20	5	0
MICHIGAN	10	40	15	15	20	0
MINNESOTA	5	25	30	20	20	0
MISSISSIPPI	10	15	30	15	20	10
MISSOURI	5	30	10	5	50	0
MONTANA	50	20	10	10	10	0
NEBRASKA	40	10	15	5	30	0
NEVADA	70	10	0	0	20	0
NEW HAMPSHIRE	70	5	10	5	10	0
NEW JERSEY	80	5	5	5	5	0
NEW MEXICO	5	30	25	25	5	10
NEW YORK	15	24	45	15	1	0
OKLAHOMA	15	25	25	20	15	0
PENNSYLVANIA	30	30	30	5	5	0
RHODE ISLAND	60	10	10	10	10	0
SOUTH CAROLINA**	70	10	10	5	5	0
SOUTH DAKOTA	30	20	20	10	20	0
TENNESSEE	15	15	40	20	10	0
TEXAS	20	20	30	20	5	5
VERMONT	5	35	30	15	15	0
VIRGINIA	30	20	30	10	6	4
WASHINGTON	50	15	10	20	5	0
WEST VIRGINIA	10	20	20	15	15	20
WISCONSIN	15	25	25	15	20	2
WYOMING	50	5	30	5	5	5
AVERAGE	41	29	37	20	19	4

TABLE SIX

STATEWIDE COVERAGE

STATE		NURSING HOMES		BOARD AND CARE		ONE HOUR COMMUTE (PERCENTAGE OF FACILITIES)	
	$/BED	STANDARD	SCORE*	STANDARD	SCORE*	Authorized	Paid
ALABAMA		No	0	No	0	40	40
ALASKA	$55.23	No	10	No	0	10	20
ARIZONA	$10.93	Week	25	Week	5	100	100
ARKANSAS	$13.38	Quarter	20	Quarter	14	60	60
CALIFORNIA	$12.60	Week	75	Month	42	60	40
COLORADO	$13.16	Month	44	Quarter	17	100	80
DELAWARE	$20.71	No	0	No	0	100	100
DIST.OF COL.	$68.05	Week	96	No	27	100	100
FLORIDA	$3.90	Annual	17	Annual	15	85	0
GEORGIA	$21.47	Month	44	Quarter	21	80	80
HAWAII	$14.10	No	0	No	0	70	70
IDAHO	$33.72	Quarter	21	Quarter	21	80	80
ILLINOIS	$8.46	Annual	21	No	0	NA	NA
IOWA	$2.09	No	0	No	0	None Cert/Auth.	
KANSAS	$4.58	No	0	No	0	48	48
KENTUCKY	$16.36	Month	41	Month	35	85	75
LOUISIANA	$14.50	Month	92	Month	44	100	100
MAINE	$9.29	No	0	No	0	50	33
MARYLAND	$10.49	Quarter	31	No	4	100	NA
MASSACHUSETTS	$33.47	Bi-week	100	Bi-week	100	100	100
MICHIGAN	$8.60	No	26	No	0		
MINNESOTA	$13.99	No	21	No	0	90	90
MISSISSIPPI	$21.47	Month	75	Quarter	44	80	80
MISSOURI	$10.19	Week	33	Week	5		
MONTANA	$5.62	Month	30	Month	46	60	20
NEBRASKA	$3.42	No	1	No	0		
NEVADA	$21.60	Bi-annual	37	Bi-annual	47	95	95
NEW HAMPSHIRE	$12.77	Month	0	Month	0	70	65
NEW JERSEY	$13.01	No	21	No	21	100	100
NEW MEXICO	$22.58	Week	50	Week	10	50	0
NEW YORK	$9.78	Week	31	Week	6	88	88
OKLAHOMA	$13.49	Week	59	Week	22	100	85
PENNSYLVANIA	$8.72	Annual	4	Annual	4	100	100
RHODE ISLAND	$5.94	No	48	No	3	100	100
SOUTH DAKOTA	$4.51	Month	44	Month	44	100	100
TENNESSEE	$9.51	Week	27	Week	11	90	90
TEXAS	$9.61	Week	75	No	0	100	30
VERMONT	$33.80	Annual	21	Annual	21	50	50
VIRGINIA	$6.88	No	20	No	20	60	60
WASHINGTON	$2.88	Week	45	Annual	2	43	43
WEST VIRGINIA	$24.78	Quarter	21	Annual	0	50	50
WISCONSIN	$7.15	Annual	44	Annual	21	60	60
WYOMING		Annual	44	Annual	44	40	40

* SCORE represents a percentage of facilities receiving weekly visits. If 100 % of all facilities receive over 40 visits per year, SCORE = 100; if 100 % are visited 24-39 times a year, SCORE = 75; if 100 % are visited 12-23 times a year SCORE = 50; if 1-11 times SCORE = 25.

** Authorized

Item 2

United States Senate
Special Committee on Aging

LEGAL ASSISTANCE SURVEY RESULTS

September, 1990

Executive Summary

In May of 1990, the Senate Special Committee on Aging sent a questionnaire to all State Agency Directors requesting information on Title III funded legal assistance. [See Attachment A] 34 states responded. The purpose of the questionnaire was to collect information regarding problems and needs within legal services programs authorized under the Older Americans Act (OAA). Survey questions examined issues concerning the legal services developer, expenditures for legal services, the definition of a "case", and the most common types of cases handled.

Legal assistance services were authorized under the original Older Americans Act legislation in 1965. The current law requires each Area Agency on Aging (AAA) to spend an "adequate proportion" of federal Title III dollars on legal assistance. What constitutes an "adequate proportion" is determined by State Agencies on Aging. If, however, an AAA can demonstrate that adequate legal services are provided in its planning and service area, the state may grant a waiver to that AAA.

Background information collected from the survey revealed that the number of Area Agencies in the state and the number of Planning and Service Areas within each state were identical in 82% of the cases. Thus, for the most part, it appears that the Area Agencies cover their Planning and Service Areas without overlap. This information paper will present a compilation of the data received as well as an analysis of this data.

Findings and Analyses

1. Legal Services Developer

In accordance with Section 307(a)(150)(c) of the OAA, the legal services developer (LSD) position was established at the state level to coordinate legal assistance programs, provide technical assistance in the provision of legal assistance to older individuals, and to furnish training and technical assistance.

Data collected pertaining to the LSD position revealed the following:

- 65% of the legal services developers are employed on a full time basis.
- 38% of legal services developers hold a law degree. Legal services developers come from a variety of educational and occupational backgrounds including: health care studies, program development, public administration, paralegal work, private legal practice, elder abuse, social work administration, and government service.
- In 68% of the responding states, the legal services developer works on issues other than those related to legal assistance. [See Attachment B]
- 18% of the LSD positions are currently vacant, and those positions have remained vacant anywhere from six months to three years.

Based on these findings, it appears that LSDs spend a majority of their time working on issues other than those relating to legal assistance. This may account for reports of LSDs' inability to focus on developing adequate legal services programs. A lack of appropriate educational background coupled with the fact that no LSD qualifications have been established by the Administration on Aging may contribute to this problem. In addition, there are no specific guidelines defining the role of the legal services developer. Finally, because the Act offers insufficiently clear directions in developing legal assistance programs, it appears that states have not been able to devote their attention to recruiting and retaining qualified individuals who can design a strong legal services network.

2. Expenditures for Title III Legal Services

A. **Legal Services Corporation Grantees.** Data received from responding states revealed that few law school programs and non-attorney advocacy programs are contracted with or funded:

- 18% of the responding states contract with law school programs to provide legal assistance under Title III-B of the OAA.
- 35% of the responding states contract with non-attorney advocacy programs to provide counseling services.

The use of unlicensed advocates who cannot practice in the courts may severely limit the ability of the programs to effectively advocate on behalf of older Americans.

B. **Total amount of Title III-B funds budgeted for legal assistance services.** Of 34 responding states, only 25 were able to provide accurate data regarding the allocation of Title III-B funds. It is particularly alarming that so many states were unable to provide the Committee with accurate data. This may reflect a serious deficiency in the ability of states to oversee and monitor their established legal services network and underscores the need for effective data collection. Data collected shows that Title III-B funds are allocated in the following manner:

- Four states allotted only 1% of their Title III budget for legal assistance. These states include Michigan, Mississippi, Pennsylvania, and Tennessee.
- States allotting from 1-3% of their Title III budget for legal assistance include Arkansas, California, Hawaii, Kentucky, Missouri, Oklahoma, Virginia, and West Virginia.
- Illinois allocates 5% of its Title III budget to legal assistance.
- Maryland allots 9% of its Title III budget to legal assistance.
- States with the highest percentage of funds allocated for legal assistance (above 10%) include Alabama, Connecticut, Florida, Maine, Washington, and Wisconsin.

It appears that a majority of the states polled designate less than 3% of their Title III-B funds to legal assistance. This is particularly surprising in light of the fact that legal assistance has been deemed a priority service. The results may indicate that there is a lack of knowledge within the Aging Network regarding what constitutes a good legal services program.

3. Minimum Percentage and Maintenance of Effort (MOE)

The 1987 amendments to the OAA required that every state set a minimum percentage of Title III-B funds to be expended by each AAA on legal services. The waiver provisions are tied to this minimum percentage.

Survey data indicate that the minimum percentages that have been set by responding states range from about 11% down to 1%. [See Attachment C]. In addition, even where the minimum percentage is set at 1%, states are still granting waivers. There are still a few states which have not set a minimum percentage as required by the 1987 amendments. This suggests a need to carefully examine the process for setting minimum percentages.

Data collected reveals that the Maintenance of Effort Provision is utilized in approximately 44% of the responding states.

4. Definition of "case"

Survey data revealed that responding states define a "case" in a variety of ways. The following are examples of the types of responses received:

- "Legal advice, counseling and representation provided by an attorney or other person under the supervision of an attorney. Includes counseling or representation by a non-lawyer, where permitted by law" (**It should be noted that this definition merely quotes current regulations);
- "A unit is one hour of legal research, legal advice, drafting of legal documents, representation of client, or instruction or training of groups";
- "Any matter in which a file is opened; may be representation in administrative or judicial hearing or extensive counseling and advice";
- "A case is a specific problem with a "case opened" point and a "case closed" point"; and
- Several agencies stated that there was no uniform definition for a case.

The variety of case definitions may account for the difficulty states have in compiling accurate data in compliance with the Act's reporting requirements. In addition, this may explain in part the difficulty AoA has encountered in analyzing data provided to them by the states pertaining to Title III-B services. Finally, the collected data underscores the need for some national direction in the way of defining what a "case"/unit of service involves.

5. **Types of cases handled**

Although the types of cases that are handled by legal services programs vary from state to state, the four most common types reported by responding states include:

- consumer protection;
- housing;
- advance directives (i.e. durable power of attorney and living wills); and
- estate and probate matters.

Eighteen of the 34 responding states reported that such case information was not available. This further highlights a lack of oversight and monitoring on the part of the states with respect to OAA funded legal assistance services. The lack of information pertaining to types of cases handled emphasizes an inability of legal assistance programs to target some of the most vulnerable of our elderly population -- i.e. low-income and minority older Americans. It may also reveal a failure on the part of the Network to focus on developing effective outreach mechanisms.

ATTACHMENT A

LEGAL ASSISTANCE QUESTIONNAIRE

1. State Unit on Aging Name/Address/Telephone:
   ____
   ____
   ____
   (   ) ____________________

2. Number of Area Agencies in State: ________

3. Number of Planning and Service Areas in State: ________

4. (a) Name/Address/Telephone number of the State OAA-funded Legal Assistance Developer:
   ____
   ____
   (   ) ____________________

   (b) Is this Legal Services Developer full-time or part-time? ________

   (c) Is the Legal Services Developer a lawyer? ________ What is that person's background? ____________________
   ____
   ____________________.

   (d) Does the Legal Services Developer work on issues other than those related to legal assistance? ______ If so, what % of his/her time is devoted to legal assistance? ______ %

   (e) If the position is vacant, how long has it been vacant?
   ____

5. (a) Number of Legal Services Corporation (LSC) grantee(s) currently under contract to provide legal assistance under Title III-B of the OAA: ______ extent of service areas for each provider (e.g. two counties): ____________________
   ____
   ____
   ____

   (b) Dollar amount and Percentage of Title III-B budget expended for such contracts in FY 89 $______, % ______and 90 $ ___, % ______

6. (a) Number of law school programs currently under contract to provide legal assistance under Title III-B of the OAA: ___; extent of their jurisdiction(s): ____________________
   ____
   ____

   (b) Dollar amount and percentage of Title III-B budget expended for such contracts in FY 89 $______, %_____ and FY 90 $____, %______

7. (a) Number of non-attorney advocacy programs currently under contract to provide advocacy and counseling services under Title III-B of the OAA: ________; extent of their jurisdiction(s): ____________________
   ____

   (b) Dollar amount and percentage of Title III-B budget expended for such contracts in FY 89 $______, %______ and FY 90 $___, %______

8. Total amount of Title III-B funds budgeted for Title III-B legal assistance state-wide for FY 89 _____ and FY 90 ______

9. Total amount of Title III-B funds obligated for FY 89 _____ and FY 90 _____

10. What is the minimum percentage of Title III-B funds that your state has set for legal assistance expenditures? _________%

11. Does the State have a Maintenance of Effort Provision?
Yes _____ No ______

12. On average, what is the number of cases that each provider handles per year? __________

13. How is a case defined in your state? (you may attach any explanatory documents that may be helpful) ___________
____
____

(a) Does the definition vary among providers? __________

(b) If so, what additional definition(s) are used? _____
____
____
____

14. What types of cases are handled? (In answering this question, please list number of cases and relative percentage of caseload as indicated in the bullets below, if available. If you maintain information by "units of service", please define what constitutes a unit of service on the lines below ______________________________
____
____):

- protective services (number of cases; percentage of caseload) __ _______; through what stages: information and referral _____, administrative review ________, court review __________, do not maintain this information ___________
- consumer protection (number of cases; percentage of caseload) _________; through what stages: information and referral ____, administrative review ______, court review _________, do not maintain this information ________
- age discrimination (number of cases; percentage of caseload) ___ _________; through what stages: information and referral _____ , administrative review _______, court review _______, do not maintain this information _______
- housing (number of cases; percentage of caseload) _____; through what stages: information and referral ________, administrative review ___________, court review _______, do not maintain this information __________
- private health care coverage (number of cases; percentage of caseload) _________; through what stages: information and referral _________, administrative review __________, court review _______, do not maintain this information _____________
- nursing home care (number of cases; percentage of caseload)___, through what stages: information and referral ____________, administrative review ____________, court review __________, do not maintain this information ______________
- guardianships and conservatorships (number of cases; percentage of caseload) _____________; through what stages: information and referral _____________, administrative review __ __________, court review _______________, do not maintain this information __________
- advance directives, ie., durable power of attorney, living wills (number of cases; percentage of caseload) ___________; through what stages: information and referral ___________, administrative review ___________, court review ________, do not maintain this information ____________
- estate and probate matters (number of cases; percentage of caseload) ___________; through what stages: information and referral ________, administrative review ____________, court review _______, do not maintain this information ____________

ATTACHMENT B

PERCENTAGE OF TIME DEVOTED BY LEGAL SERVICES DEVELOPER STATE BY STATE

ILLINOIS	100%
KENTUCKY	20%
WEST VIRGINIA	40%
ARKANSAS	35%
WASHINGTON	75%
MISSOURI	30%
MONTANA	75%
MAINE	50%
VIRGINIA	20%
CONNECTICUT	20%
DISTRICT OF COLUMBIA	100%
WISCONSIN	80%
NEW HAMPSHIRE	33%
ALABAMA	40%
FLORIDA	25%
RHODE ISLAND	100%
MARYLAND	100%
IOWA	80%
WYOMING	90%
MISSISSIPPI	55%
SOUTH DAKOTA	50%
NEBRASKA	10-40%
OKLAHOMA	100%
HAWAII	---
MICHIGAN	75%
SOUTH CAROLINA	25%
NORTH CAROLINA	10%
PENNSYLVANIA	5%
UTAH	75%
CALIFORNIA	N/A
TEXAS	100%
TENNESSEE	100%
PUERTO RICO	N/A
MINNESOTA	100%

ATTACHMENT C

MINIMUM PERCENTAGE OF TITLE III-B FUNDS STATE BY STATE

ILLINOIS	3.2%
KENTUCKY	----
WEST VIRGINIA	****
ARKANSAS	----
WASHINGTON	11.0%
MISSOURI	1.0%
MONTANA	2.0%
MAINE	10.0%
VIRGINIA	1.0%
CONNECTICUT	8.0%
DISTRICT OF COLUMBIA	----
WISCONSIN	5.0%
NEW HAMPSHIRE	9.3%
ALABAMA	6.7%
FLORIDA	1.0%
RHODE ISLAND	----
MARYLAND	7.0%
IOWA	3.0%
WYOMING	----
MISSISSIPPI	3.5%
SOUTH DAKOTA	2.0%
NEBRASKA	2.0%
OKLAHOMA	----
HAWAII	10.9%
MICHIGAN	5.0%
SOUTH CAROLINA	1.0%
NORTH CAROLINA	2.0%
PENNSYLVANIA	1.0%
UTAH	2.0%
CALIFORNIA	It varies
TEXAS	2.0%
TENNESSEE	6.0%
PUERTO RICO	3.0%
MINNESOTA	5.0%

---- Information not available.

**** Same percentage as Maintenance of Effort.

REAUTHORIZATION OF THE OLDER AMERICANS ACT

(Workshop No. 4)

WEDNESDAY, OCTOBER 18, 1990

U.S. Senate,
Special Committee on Aging,
Washington, DC.

The workshop was held in the Dirksen Senate Office Building, Senator David Pryor presiding.

Staff present: Portia Porter Mittelman, staff director; Christopher Jennings, deputy staff director; John Monahan, professional staff; Anna Kindermann, professional staff; Heather Burneson, professional staff; Diane Braunstein, minority professional staff.

OPENING REMARKS BY ANNA KINDERMANN, PROFESSIONAL STAFF, SPECIAL COMMITTEE ON AGING

Ms. Kindermann. My name is Anna Kindermann. I am a professional staff member with the Senate Special Committee on Aging. Before I turn this over to our moderator, I would just like to take time to extend my thanks to some of those people who made this workshop possible today.

First of all, I would like to introduce our staff director, Portia Mittelman, sitting behind me. Her continuing support in all of our efforts and in working on the reauthorization of the Older Americans Act has been particularly helpful. I would also like to extend my special thanks to Amy Lauth, who is sitting to my right. She has been a wonderful intern, who stayed late with me last night to work on this.

To my left is my mentor, John Monahan, who works with the personal staff of Senator Pryor's office. Finally, there is Diane Braunstein from Senator Heinz' office, the minority staff of the committee. Diane Braunstein has maintained her good humor while working furiously on the budget reconciliation and continued to work with me as well.

STATEMENT OF DIANE BRAUNSTEIN, MINORITY STAFF, SPECIAL COMMITTEE ON AGING

Ms. Braunstein. On behalf of Senator Heinz, I would like to welcome you all here today. I also want to thank you for your participation and I just look forward to hearing all of your comments and learning a great deal from all of you.

Thank you.

Ms. Kindermann. I think we can get started now, and I will turn it over to our moderator, Mr. James Musselwhite from the General Accounting Office.

STATEMENT OF JAMES MUSSELWHITE, GENERAL ACCOUNTING OFFICE

Mr. Musselwhite. I would like to start this morning by doing two things. First, I will provide a few remarks by way of background to provide some context for today's discussion. Second, I will say a word or two about what my role as moderator will be.

We have an opening statement from Senator Pryor that is included in your packets. We are expecting him a little later in the proceedings.

[The prepared statement of Senator Pryor follows:]

STATEMENT OF SENATOR DAVID PRYOR
CONCLUDING OLDER AMERICANS ACT WORKSHOP
OCTOBER 18, 1990

Thank you very much for attending the final installment in a series of legislative workshops concerning the reauthoriation of the Older Americans Act. As you know, this workshop series is sponsored by the Special Committee on Aging. The series has provided members of the Committee an opportunity to hear the views of individuals directly involved in the provision of services to Older Americans.

Before turning to today's agenda I would like to stress the informal nature of the workshop format. I am proud to say that the Aging Committee has been very successful in experimenting with this alternative to legislative hearings -- a forum which allows for critical give-and-take between interested persons.

I hope today's workshop will maintain the informality it has been designed to foster and I urge all members of the audience to participate actively. The success of the discussion today depends upon your open and active participation.

Let me now turn to the issues on today's agenda.

First, I hope that our panelists will focus our attention on the critical role which the Administration on Aging plays in the implementation of the Older Americans Act, and how that role might be strengthened in the 1991 reauthorization. The Administration on Aging has primary responsibility for the administration of programs authorized under the Older Americans Act. Given this statutory authority, it is crucial that the Administration on Aging be afforded every opportunity to improve its effectiveness in meeting the Act's objectives. I hope that this session will spark ideas:

- For improving the dissemination of information within the Aging Network;
- For providing the state units on aging and area agencies on aging the technical assistance they need; and,
- For supporting those who are actually engaged in the provision of services to older Americans.

Ideas such as these will help to ensure that the Administration on Aging will keep up with a continually graying America.

In conclusion, I again thank all of you for attending this final legislative workshop. I am anxious to hear your thoughts and ideas, as we look forward to next year's reauthorization of this legislation which continues to prove essential to the lives of our senior citizens.

OLDER AMERICANS ACT INFORMATION SHEET

The Older Americans Act (OAA) was enacted in 1965, and has been reauthorized on ten occasions, most recently in 1987. The Act serves to improve the lives of all older Americans in a variety of areas including income, health, nutrition, employment, and long-term care, among others.

The Act establishes an Administration on Aging (AoA), within the Department of Health and Human Services, to administer the majority of the OAA programs and to act as the chief Federal agency advocate for the elderly. The AoA oversees a network of state and area agencies on aging. The state and area agencies on aging maintain responsibility for funding, coordinating and managing a broad array of service programs and other initiatives for the elderly. In addition to priority areas specified in the Act, local services are supported in response to the needs of individual communities. The OAA also establishes a Federal Council on Aging to advise the President and Congress regarding the needs of the elderly.

State units on aging (SUAs) receive federal funds for implementation of state plans on aging which the AoA has approved. Area agencies on aging (AAAs) then develop and fund services based upon state approved area plans on aging. Primarily through subgrants and contracts with local service providers, AAAs seek to meet the needs of the elderly populations within their jurisdictions. Today there is an "aging network" which includes an aging unit in each state, approximately 670 area agencies on aging, and more than 25,000 local service providers. In addition, the OAA continues to serve as a vehicle for the education and training of thousands in the field of aging.

Congress has scheduled the OAA for reauthorization in 1991. In order to identify key issues that may merit close examination as part of the reauthorization process, the Senate Special Committee on Aging is sponsoring a series of workshops in 1990. By obtaining information and opinions from experts in academia, government, advocacy organizations, social services agencies, and other sectors, the key issues for consideration will be identified. In addition, it is expected that legislative changes that may be necessary or desirable as part of the reauthorization process will be suggested.

The final session of this workshop series will focus on issues pertaining to the administrative implementation of the OAA, including the role of the Administration on Aging (AoA). A panel of experts from various parts of the aging community will address the following pertinent issues:

- Whether AoA is in a position to fulfill its analytical and educational role, given limited resources and staffing;
- Whether the current position of the AoA within the Department of Health and Human Services is the most advantageous to fulfilling AoA's charge;
- Whether AoA is providing sufficient technical assistance to SUAs and AAAs in order to facilitate the operation of OAA services;
- Whether and how AoA can be more effective in improving the efficiency, coordination, and dissemination of data collection;
- What steps might AoA take in order to assure more effective coordination with other federal agencies;
- Whether the duties set forth in Title II adequately respond to needs at the state and local level; and
- What is the role of the Federal Council on Aging? What should that role be?

Panelists representing levels of the Aging Network will focus their presentations and discussion on these administrative issues. Ms. Carol Crecy, Acting Deputy Associate Commissioner for State and Community Programs of the Administration on Aging will provide the Administration on Aging's perspective on some of the issues; Mr. Herb Sanderson, Director, Division of Aging and Adult Services, Little Rock, Arkansas will address these issues from a state perspective; Mr. Edward J. Keenan, Director, Montogomery County Aging and Adult Services, Norristown, Pennsylvania, who will provide an area agency on aging viewpoint; Mr. O. Lewis Harris, Director, Forest Hills Community House, Forest Hills, New York, who will address administrative issues from the standpoint of an urban service provider; and Mr. Sidney Murphy, Director, Preston County Senior Citizens, Inc., Kingwood, West Virginia, who will follow with the perspective of a rural service provider.

Mr. James C. Musselwhite, Senior Social Science Analyst, U.S. General Accounting Office, will serve as the moderator for the discussion. Full and open audience discussion will follow the presentations of the panelists.

October 18, 1990

OLDER AMERICANS ACT AUTHORIZATION LEVELS AND APPROPRIATIONS
FISCAL YEARS 1988-91

AUTHORIZATION LEVELS
FY88-91 [in thousands of dollars]

Act Title and Services	1988	1989	1990	1991
Title II				
Federal Council on the Aging	$210	$221	$232	$243
Title III				
Grants for State and community programs on aging:				
Supportive services and centers	379,575	398,554	418,481	439,406
Nutrition services	645,130	684,837	727,778	773,017
Congregate	(414,750)	(435,488)	(457,262)	(480,125)
Home Delivered	(79,380)	(83,349)	(87,516)	(91,892)
USDA Commodities	[1](151,000)	[1](166,000)	[1](183,000)	[1](201,000)
In-home services for frail elderly	25,000	26,250	27,563	28,941
Assistance for special needs	[3]25,000	[3]25,000	([3]—[4])	([3]—[4])
Health education and promotion	[3]5,000	([3]—[4])	([3]—[4])	([3]—[4])
Elder abuse prevention	[3]5,000	([3]—[4])	([3]—[4])	([3]—[4])
Long-term care ombudsman	[3]20,000	([3]—[4])	([3]—[4])	([3]—[4])
Outreach for SSI, Medicaid and food stamps	(-[2])	[3]10,000	[3]10,000	([4])
Title IV				
Training, research and discretionary projects and programs	32,790	34,619	36,349	38,167
Home care demonstration projects	(-[2])	[3]2,000	[3]2,000	(-[2])
Ombudsman and advocacy demonstration projects	(-[2])	[3]1,000	......	(-[2])
Title V				
Community service employment for older Americans	386,715	406,051	426,353	447,671
Title VI				
Grants for Native Americans	[5]13,400	[5]16,265	[5]19,133	[5]22,105
Part A - Indian Program	(12,100)	(14,900)	(17,700)	(20,600)
Part B - Native Hawaiin Program	(1,300)	(1,365)	(1,433)	(1,505)
Title VII				
Older Americans personal health education and training program	(-[6])	(-[6])	(-[6])	(-[6])
Total	[7]1,538,000	[7]1,604,797	[7]1,667,889	[7]1,749,550

[1] Public Law 100-175 requires the Secretary of Agriculture to main a reimbursement level of 56.76 cents per meal for fiscal year 1986-91.

[2] Not authorized.

[3] The law requires that total appropriations for programs funded in fiscal year 1987 increase by at least 5 percent over the previous year before appropriations for these new authorizations are made.

[4] Such sums as may be necessary.

[5] The law creates a separate Part B for funds for a Native Hawaiian program. As shown in the table, the law authorizes specific amounts for Part A, the Indian Program, and for Part B. The law further specifies that Part B receive funding only if the total appropriations for title VI exceed the fiscal year 1987 funding level ($7.5 million). Part B will receive the first $250,000 of any appropriations exceeding the fiscal year 1987 level, and half of any increase above the first $250,00 up to the authorized amount.

[6] This title is repealed.

[7] Plus such sums as may be necessary for certain programs.

APPROPRIATIONS
FY88-90 [in thousands of dollars]

Act Title and Services	1988	1989	1990 (post sequestration)
Title II			
Federal Council on the Aging	$191	$188	$186
Title III			
Grants for State and community programs on aging:			
Supportive services and centers	268,072	274,352	271,987
Nutrition services	560,611	576,507	574,387
Congregate	(344,664)	(356,668)	(351,924)
Home Delivered	(75,635)	(78,546)	(78,981)
USDA Commodities	(140,312)	(141,293)	(143,482)
In-home services for frail elderly	4,787	4,834	5,756
Assistance for special needs	none	none	none
Health education and promotion	none	none	none
Elder abuse prevention	none	none	none
Long-term care ombudsman	957	988	974
Outreach for SSI, Medicaid and food stamps	none	none	none
Title IV			
Training, research and discretionary projects and programs	23,935	22,173	25,332
Home care demonstration projects	(—)	none	— —
Ombudsman and advocacy demonstration projects	(—)	none	— —
Title V			
Community service employment for older Americans	331,260	343,824	357,013
Title VI			
Grants for Native Americans	7,181	10,710	12,541
Part A - Indian Program	— —	— —	— —
Part B - Native Hawaiin Program	— —	— —	— —
Title VII			
Older Americans personal health education and training program	(—)	(—)	— —
Total	$1,196,994	$1,233,576	$1,248,176

Mr. MUSSELWHITE. As you know, this is the last in a series of four workshops on the Older Americans Act that the Senate Special Committee on Aging has sponsored. The first workshop was an overview of the Older Americans Act and dealt with issues of targeting and gap filling. The second workshop dealt with information and referrals and information sharing in the aging network.

The third workshop dealt with long-term care, ombudsman issues, and legal assistance. Today's session will deal with administrative implementation of the Older Americans Act and the role of the Administration on Aging.

We are all celebrating this year the 25th anniversary of the Older Americans Act's services to our Nation's older citizens. At the same time, all of you in the aging network are thinking about issues that will be discussed and deliberated over in the reauthorization process next year. This workshop is a part of the Senate Aging Committee's strategy for collecting information from you that might be useful in those hearings.

We know that in the last decade and well into the future for as far as we can see, the Nation's elderly population has been increasingly and will continue to do so. Today, there are approximately 32 million persons 65 years of age and older. By the year 2020, an estimated 52 million persons will be 65 years and older. Of course, the old old population is increasing even more dramatically.

When we think about the Older Americans Act, I think it is important to keep in context that we are talking about a budget of approximately $1.2 billion. Then when we think about the role of the Administration on Aging, we want to remember that not all of those dollars are administered by the Administration on Aging. Approximately $750 million are administered by the agency, and most of those dollars are Title III dollars which go to the States in the form of grants.

In addition to the increase in the elderly population across the country, in response to that increase, we have seen a whole slew of program development and service development in the last decade at the Federal, State, and local levels and in the private sector that has changed the environment in which the Older Americans Act works today and in which the Administration on Aging functions. In your comments today, I expect that many of you will address some of the concerns that arose out of changes in the service environment, changes that have occurred since the initial passage of the Act in 1965.

Our task, then, will be to think about and suggest ways that we can improve the Older Americans Act and the role of the Administration on Aging as we go into the 1990's. So much for context.

Let me say a word about my role as moderator. First, I will be introducing speakers. Second, I guess my most important role is going to be to encourage your active participation in the process. We think of this as a very informal process and encourage you to participate to give us the benefit of your knowledge and insight in terms of administrative implementation of the Older Americans Act and the role of the Administration on Aging in the Act.

There are microphones all around the tables. We also have a microphone to my right. After our speakers give their presentations, we will open the floor and hope that as many of you as possible will come forward to take advantage of the opportunity to provide us with your ideas. When you do so, please keep in mind that we would like to have your name and where you are from so that can be part of the record.

At this point, I would like to introduce our first speaker and welcome her. We look forward to her presentation.

Carol Crecy is representing the Administration on Aging today. She is currently the Acting Deputy Associate Commissioner in the Office of State and Community Programs at the Administration on Aging. This, of course, is the section that administers the Title III program, grants to the States.

She has been in Federal Service for 18 years. Prior to her current position, she was Special Assistant to the Commissioner for Minority Affairs at the Administration on Aging. She has also been Director of the Division of Policy, Planning, and Administration. Before that, she was Director of the Division of Community Based Systems Implementation.

She has worked in the Office of the Assistant Secretary for Health in HHS. She truly has a wealth of Federal experience and brings a broad perspective in terms of how the Administration on Aging's programs work.

Carol, I will turn it over to you.

STATEMENT OF CAROL CRECY, ADMINISTRATION ON AGING

Ms. Crecy. Good morning, Jim Musselwhite, members of the panel, and audience.

The Administration on Aging appreciates the opportunity to participate in this workshop and to present comments on some of the issues related to reauthorization of the Older Americans Act in which you have expressed an interest. The Commissioner on Aging, Dr. Joyce Berry, regrets that she is not able to be here today because she had a previous commitment. My presentation today will touch briefly on areas which you have identified in the letter of invitation and will describe some of the activities in which AOA is presently engaged in each of the issue areas.

First, there is AOA's analytical and educational role. AOA's fiscal year 1990 discretionary funds program continues the emphasis on education and training evident in previous years. Applications were solicited and Title IV funds awarded in such priority areas as training and technical assistance to State and area agencies on aging, on working collaboratively with the private sector, and collaborative curriculum development projects between State education departments and State agencies on aging.

In addition, the fiscal year 1990 Title IV program supports projects across a wide range of manpower development concerns: for example, faculty and program development. Support for the minority management training program has continued throughout this reauthorization period.

AOA's position within the Department of Health and Human Services is next. Since shortly after the passage of the 1987 amendments to the Older Americans Act, the Commissioner on Aging has reported directly to the Secretary of the Department in all policy matters. Following the issuance of a memorandum by former Secretary Bowen, the Commissioner has regularly attended the Secretary's senior staff meetings as a full participant and member of the Secretary's senior staff.

As in the past, administrative services are provided to the Administration on Aging by the Office of Human Development Services. The agency's ability to sit at the table with the Secretary and other operating divisions of the Department as policy matters relating to older people are discussed has been an invaluable asset allowing the Agency to effectively carry out its Title II responsibilities.

Third is the area of technical assistance to State and area agencies on aging. Technical assistance is provided to State and area agencies on aging through a variety of measures, not the least of these being the provision of direct technical assistance by AOA's 10 regional offices.

In addition, the Commissioner on Aging meets quite frequently with representatives of State and area agencies on aging to determine additional ways in which AOA can be of assistance. Since assuming the responsibility of Commissioner on Aging, Dr. Berry has heavily stressed continuing dialogue and communication with all members of the entire aging network, including State and area agencies on aging. This is to ensure that AOA's technical assistance efforts are directed toward meeting the most important needs.

Also, the Administration on Aging makes extensive use of its Title IV resources to develop and extend technical assistance and training to those at the State and community levels responsible for planning, providing, and evaluating services to older persons. Title IV funds have been used to support leadership institutes, resource centers, and other activities, all of which include the provision of technical assistance and training as a major component of their respective program activities.

Despite what we have done in the past, we believe that our network continues to need serious training and technical assistance on information and referral. AOA has recently funded a major effort in this area to strengthen information and referral services, increase the professionalism of these services, and establish quality standards for implementation.

Next is AOA's efforts to improve efficiency, coordination, and dissemination of data. In the last several years, AOA has placed an ever-increasing emphasis on the improvement of program data collection and on the dissemination of data which are relevant for planning purposes nationwide.

As you know, the 1987 amendments call for the collection and reporting of new program data from State and area agencies on aging. In order to meet the requirement, we revised the data collection instruments as rapidly as possible and offered technical assistance to States in the use of the collection instruments.

As the collection of new data required a phasing-in period, we have only now collected the first year's data. We have already identified some gaps in the data and some problems in the instrument. Therefore, the Commissioner is establishing a task force of State and area agency suggested by State and area agency directors and others, and make recommendations to improve the quality and compatibility of data submitted by the States.

While we think this is an extremely important step in redefining the data collection process, the aging network has urged us to move cautiously as we attempt to revise the instrument, thinking through all of the ramifications of any proposed change. We do intend to approach the revision process thoughtfully and with appropriate consultation from those groups from whom the data will be collected in coordination with other Federal agencies.

During Commissioner Berry's tenure as Commissioner on Aging, I believe she has worked tirelessly to improve coordination with other Federal agencies. In addition to affecting numerous inter- and intra-agency agreements and memoranda of understanding, she has initiated an interdepartmental task force on aging. The purpose of this task force is to identify issues for policy and program coordination and to develop collaborative interdepartmental approaches in preparation for the changing and growing aged population.

The next topic is the activity under Title II. Elsewhere in the statement, I have described a number of activities in which AOA is engaged which address the requirements of Title II. These activities include provision of technical assistance to State and local agencies on aging, collection and dissemination of data on aging, service as an advocate for older persons, aging services programs within the Department of Health and Human Services and with other agencies in the Executive Branch, and the promotion and program coordination. Within the framework of AOA's annual goals, we are focusing heavily on Title II activities in all of our efforts.

Finally, we have recently established a private sector management committee to increase awareness of the challenges of changing demographics and to stimulate the expansion of services and resources for older persons by promoting and expanding public/private partnerships. The responsibilities assigned to AOA and the Commissioner under Title II provide a broad mandate for the agency to furnish aggressive leadership in the field of aging.

I can assure the Committee and the workship participants that Commissioner Berry takes this leadership responsibility very seriously. We, as an agency, will continue to see that these responsibilities are carried out effectively.

In summary, the Administration on Aging has taken and is continuing to take timely actions to fulfill the requirements of the 1987 amendments and to carry out the intent of Congress. The Older Americans Act has been enormously successful in serving this Nation's older population. We believe that the 1987 amendments made the Act an even more effective statute on behalf of elderly persons, and we look forward to working with you as you continue your efforts to further fine tune the Older Americans Act in the upcoming reauthorization process.

This concludes my prepared remarks. I am available for any questions.

Thank you.

[The prepared statement of Ms. Crecy follows:]

STATEMENT BY

CAROL CRECY

ADMINISTRATION ON AGING

BEFORE THE

SENATE SPECIAL COMMITTEE ON AGING

WORKSHOP ON REAUTHORIZATION OF THE
OLDER AMERICANS ACT

"The Administration on Aging:
Meeting the Challenge of A Graying America"

Introduction

Mr. Chairman and Members of the Special Committee on Aging: The Administration on Aging appreciates the opportunity to participate in this workshop and to present comments on some of the issues relating to reauthorization in which you have expressed an interest. We are proud of the progress the Administration on Aging has made in implementing the 1987 Amendments to the Older Americans Act, and we would like to report to you on some of the special initiatives, in the issue areas your committee is addressing today, which we have undertaken since passage of the 1987 Amendments. We are also keenly aware that much remains to be done. The Commissioner on Aging, Dr. Joyce T. Berry, sends her personal greetings and regrets that she is unable to be with you today due to a previous commitment.

My presentation will touch briefly on areas which you identified in the letter of invitation, and will describe some of the activities in which AoA is presently engaged in each of the issue areas. These are: (1) AoA's analytical and educational role; (2) its current position within the Department of Health and Human Services; (3) how AoA is providing technical assistance to SUAs and AAAs in order to facilitate the operation of Older Americans Act services; (4) AoA's efforts to improve the efficiency, coordination, and dissemination of data collection; (5) what steps AoA is taking to assure more effective coordination with other Federal agencies; and (6) whether the duties set forth in Title II adequately respond to needs at the State and local level.

1. AoA's Analytical and Educational Role

Sections 410 and 411 of the Older Americans Act authorize the award of grants and contracts to assist in recruiting persons, including minorities, to enter the field of aging; to train professional and paraprofessional persons employed in or preparing for employment in fields having an impact on the aging; and to provide for technical assistance and other activities related to training. AoA's activities in support of technical assistance efforts are outlined elsewhere in this statement. Recent efforts on AoA's part to provide education and training opportunities for those in the aging field are described below.

In FY 1989, AoA supported a broad range of activities designed to encourage the inclusion of aging content in educational programs leading to certification or academic degrees for persons (both professionals and paraprofessionals) in the field of aging or preparing to enter the field. In addition, AoA used FY 1989 Title IV resources to support a series of in-service and continuing education programs for persons currently employed in occupations serving the elderly. FY 1989 Title IV funds also provided on-going support for grants in the area of Minority Training and Development.

AoA's FY 1990 Discretionary Funds (Title IV) Program continues the emphasis on education and training evident in previous years. Applications were solicited, and Title IV funds awarded, in such priority areas as "Training and Technical Assistance to State and Area Agencies on Aging on Working Collaboratively with the Private Sector" and "Collaborative Curriculum Development Projects Between State Education Departments and State Agencies on Aging". In addition, the FY 1990 Title IV program supports projects across a wide range of "Manpower Development" concerns, e.g., "Faculty and Program Development". Support for the "Minority Management Traineeship Program" is also provided using FY 1990 Title IV resources.

2. AoA's Position within the Department of Health and Human Services

Since shortly after passage of the 1987 Amendments to the Older Americans Act, the Commissioner on Aging has reported directly to the Secretary of the Department in all policy matters. Following the issuance of a memorandum by former Secretary Bowen on January 28, 1988 to this effect the Commissioner has regularly attended the Secretary's senior staff meetings as a full participant and member of the Secretary's Senior Staff. As in the past, administrative services are provided to the Administration on Aging by the Office of Human Development Services. However, this does not impede the agency's ability to sit at the table with the Secretary and other Operating Divisions of the Department as policy matters relating to older people are discussed.

3. Technical Assistance to SUAs and AAAs

Technical assistance is provided to the State Units on Aging and to Area Agencies through a variety of measures emanating from the Administration on Aging, not the least of these being the provision of direct technical assistance by AoA's ten Regional Offices to the States within each Federal region. Regional Offices also convene periodic meetings with State Agencies on Aging to assist them in their responsibilities. In addition, the Commissioner on Aging meets quite frequently with representatives of the State and Area Agencies on Aging to determine additional ways in which AoA can be of assistance. Since assuming responsibility as Commissioner on Aging, Dr. Berry has heavily stressed continuing dialogue and communication with all members of the entire aging network, including State and Area Agencies on Aging, to ensure that AoA's technical assistance efforts are directed toward meeting the most important needs of older Americans.

The Administration on Aging has also implemented a number of initiatives at the Federal level and has utilized a portion of its Title IV resources to assure the ongoing provision of technical assistance to State and Area Agencies on Aging. Some of these initiatives are outlined below.

- AoA has prepared and distributed two Program Instructions (PI's) on targetting of services; one of the PI's addresses the intra-State funding formula issue while the second focuses on older Indians.

- AoA has also provided the State and Area Agencies on Aging with a PI on Elder Care.

- AoA has furnished the States with information on the Supplemental Security Income, Medicaid and Food Stamp Programs in order to facilitate outreach to older persons who are eligible for, but not participating in, these programs.

- Through a variety of communication instruments such as Information Memoranda and Open Letters to State Agency on Aging Directors, AoA systematically provides information on collaborative efforts at the Federal level which should be of assistance to State and Area Agencies on Aging in improving coordination of planning and services at the State and local levels.

The Administration on Aging makes extensive use of its Title IV resources to develop and extend technical assistance and training to those at the State and community levels responsible for planning, providing, and evaluating services to older persons. Title IV funds have been used to support leadership institutes, resource centers, and other activities, all of which include the provision of training and technical assistance as a major component of their respective program activities. These Title IV efforts are discussed in more detail below.

Leadership Institutes

In recent years, AoA has funded two leadership institutes using Title IV resources. These are the **National Leadership Institute on Aging** and the **Native American Leadership Institute**. Residential seminars conducted by the **National Leadership Institute** assist aging network executives to examine and develop their leadership styles and capacities; these seminars challenge and inspire those in leadership positions to seek new ways to fulfill their roles in a rapidly aging society.

The **Native American Leadership Institute**, which is operated by Three Feathers Associates under a Title IV grant, provides comprehensive training to directors of projects funded under Title VI of the Older Americans Act. The training is designed to increase the competencies and leadership skills of Title VI directors in managing multi-service programs for older Indians and Alaskan Natives. Specific curriculum elements include legislative and administrative history of aging services, program planning and implementation, program management, and gerontology issues.

Resource Centers

Six national Aging Resource Centers on Long-Term Care were established in FY 1988 for a three year period to provide training and technical information to State and Area Agencies on Aging to assist these agencies in working with communities, public and private organizations, individual professionals, and members of the public in planning and implementing long-term care services for older persons.

Each of the six Resource Centers has expertise in a specific area of the long-term care field. These areas of expertise include case management, data collection and analysis, long-term care management of patients suffering from Alzheimer's Disease, Medicaid coordination, training of home care personnel, and supportive services in adult housing. Centers collect information and research results, produce issue synthesis papers, and provide consultations, training, and assistance to State and Area Agencies on Aging.

The specialties of each of the six centers and their sponsoring institutions are listed below.

- "Planning and Management of Community-Based Care" - Brandeis University
- "Decisions [about long-term care] by Older Persons, Families and Providers" - University of Minnesota
- "Linkages between Aging Network, Hospitals and Residential Facilities" - University of California, Los Angeles
- "State Management of Community-Based Care Systems" - National Association of State Units on Aging
- "Alzheimers Disease and Other Dementias" - University of South Florida
- "Aging, Disability and Long-Term Care" - Indiana University/Indianapolis (in conjunction with other Indiana University components, Notre Dame, and Purdue)

In addition, AoA has also used Title IV funds to establish five other Centers which, among other activities, provide technical assistance and training to components of the aging services network. The Center for State Long Term Care

Ombudsman Resources is operated jointly by the National Association of State Units on Aging and the National Citizens Coalition for Nursing Home Reform. In its first year the Ombudsman Resources Center held multi-regional teleconferences for information-sharing among States, conducted a National Training Conference for ombudsman and State staff, and developed two training modules for States to use training local ombudsmen. The **National Resource Center on Health Promotion and Aging**, operated by the American Association of Retired Persons, provides training and technical assistance, as well as other resources to agencies and organizations involved in health promotion activities focused on older persons.

Three other Resource Centers have responsibilities in the areas of elder abuse, minority aging and the rural elderly. The **National Aging Resource Center on Elder Abuse**, led by the American Public Welfare Association in collaboration with the University of Delaware and the National Association of State Units on Aging, serves as a resource of information, data and technical expertise on elder abuse to State and local aging and adult protective service personnel, to other professionals concerned with elder abuse, and to the public. The **National Resource Center on Minority Aging Populations**, a collaborative venture between San Diego State University and the University of Southern California, serves as a national focal point for technical assistance, training, information dissemination, and short-term research. The **National Resource Center for Rural Elderly**, at the University of Missouri, Kansas City, also offers technical assistance, training, information dissemination and short-term research services.

State Grants for Frail Elderly

In FY 1990, nine State Agencies on Aging were funded to carry out collaborative ventures with other State Agencies and other parts of the aging network to plan and implement improvements in community-based long-term care.

Community Focal Points

Recognizing the important role which community focal points can play in community based systems, AoA awarded a contract in FY 1989 to provide technical assistance and training to States in the use of focal points to promote access to services and responsiveness of service systems. Trainees include representatives from State and Area Agencies on Aging, as well as AoA Regional Offices.

In addition, I believe that despite what we have done in the past, our network needs serious training and technical assistance on information and referral. I intend to support a major effort in this area to strengthen information and referral services, increase the professionalism of these services, and establish quality standards for implementation.

4. AoA's Efforts to Improve the Efficiency, Coordination, and Dissemination of Data

In the last several years, AoA has placed an ever-increasing emphasis on the improvement of program data collection and on the dissemination of data which are relevant for planning purposes nationwide.

As you know, the 1987 Amendments called for the collection and reporting of new program data from State and Area Agencies on Aging. In order to meet that requirement we revised the data collection instruments as rapidly as possible and offered technical assistance to the States in the use of the collection instruments. As the collection of the new data required a "phasing-in" period, we have only now collected the first year's data and have begun analyzing the data. We have already identified gaps in the data and problems in the instrument and have developed a plan for improving the instrument.

The Commissioner is establishing a Task Force of State and Area Agency on Aging representatives to evaluate the current form, review changes suggested by State and Area Agency Directors and others, and make recommendations to improve the quality and compatibility of data submitted by the States. While we think this is an extremely important step in refining the data collection process, the aging network has urged us to move cautiously as we attempt to revise the instrument, thinking through all ramifications of change. We do intend to approach the revision process thoughtfully and with appropriate consultation with those groups from whom the data will be collected.

As for the dissemination of data, we have undertaken a special initiative in this area which we believe will have considerable influence on planning for at least the coming decade.

- AoA is sponsoring a special tabulation of 1990 census sample data. The primary purpose of this project is to develop statistical information useful to State and Area Agencies on Aging in planning and evaluating aging programs.
- Current plans call for establishment of a work group which is to complete the development of the specifications by the end of 1990. The Bureau of the Census will begin writing computer programs to prepare the tabulation in fiscal year 1991. The project should be completed in fiscal year 1992, at which time the Bureau of the Census will disseminate the results to State and Area Agencies on Aging.

5. Coordination with Other Federal Agencies

During Commissioner Berry's tenure as Commissioner on Aging, I believe she has worked tirelessly to improve coordination with other Federal agencies.

In addition to effecting numerous inter- and intra-agency agreements and memoranda of understanding, she has initiated an Interdepartmental Task Force on Aging with the following objectives:

- to identify issues for policy and program coordination;
- to develop collaborative interdepartmental approaches in preparation for the changing and growing aged population; and
- to establish work groups to address issues of concerns and present recommendations to the Task Force.

The first meeting of the Interdepartmental Task Force on Aging was convened on June 20, 1990. The Task Force is comprised of representatives from the Department of Education, the Department of Veterans Affairs, the Department of Labor, the Department of Housing and Urban Development, the Department of Transportation, the Department of Agriculture, the Social Security Administration, the Health Care Financing Administration, the National Institute on Aging, the Family Support Administration, and the Health Resources and Services Administration.

The Task Force has identified four work groups -- Housing, Employment/Volunteers, Health, and Community-Based Care Services.

6. Activities Under Title II in Support of State and Local Aging Programs

Elsewhere in this statement I have described a number of activities in which AoA is engaged which address the requirements of Title II. These activities include provision of technical assistance to State and local programs, collection and dissemination of data on aging, service as an advocate for older persons and aging services programs within the Department of Health and Human Services and with other agencies in the Executive Branch, and promotion of program coordination. Within the framework of AoA's Annual Goals, we are focussing heavily on Title II activities in all our efforts.

In addition, AoA has taken steps to establish the Office of American Indian, Alaskan Native and Native American Programs and to assure that recurring Title II responsibilities for publishing the Annual Report and the annual statement of agency goals are properly discharged. Over the years we have also conducted a wide range of evaluation projects designed to assess the impact of aging services programs and activities.

Finally, we have recently established a Private Sector Management Committee to increase awareness of the challenges of the changing demographics and to stimulate the expansion of services and resources for older persons by promoting and expanding public/private partnerships. Members of the Committee will include representatives from businesses and industries which have demonstrated an interest in older persons and their families; have recognized the importance of strengthening and expanding public-private partnerships; and can play a leading role in broadening the base of private sector support for age-related policies and programs.

Individually or collectively, members will assist in the development and implementation of various public-private initiatives.

The responsibilities assigned to AoA and the Commissioner under Title II provide a broad mandate for the agency to furnish aggressive leadership for the aging field. I can assure the Committee and the Workshop participants that Commissioner Berry takes these leadership responsibilities very seriously. We, as an agency, will continue to see that these responsibilities are carried out effectively.

Conclusion

In summary, the Administration on Aging has taken, and is continuing to take, timely actions to fulfill the requirements of the 1987 Amendments and to carry out the intent of Congress. The OAA has been enormously successful in serving this nation's growing older population. We believe that the 1987 Amendments made the Act an even more effective statute on behalf of elderly persons, and we look forward to working with you as you continue your efforts to further fine-tune the Older Americans Act in the upcoming reauthorization process.

Mr. Chairman, this concludes my prepared remarks. I will be happy to respond to any questions which you and the other Committee members may have. Thank you.

Mr. **Musselwhite**. Thank you very much, Carol, for that presentation. You certainly laid out a lot of information that I am sure will spark debate and interest as we go along in this session today.

Our next speaker represents a different perspective in the aging network, that of a State agency on aging. We are very happy to welcome Herb Sanderson, who is the Director of the Division of Aging and Adult Services in Little Rock, AR.

He has served for 3 years in the Maternal and Child Health Division of the Arkansas Department of Health. For 7 years, he was Executive Director of the East Arkansas Area Agency on Aging. In 1984 he was appointed by Governor Clinton to his present position.

He has been on the board of directors of many aging agencies and association in Arkansas and he currently serves on the Board of Directors of the Governor's Developmental Disabilities Planning Council. He is also on the Supported Housing Task Force and the Health Care Financing Administration's Home and Community Based Services Technical Advisory Group.

We are very happy to have him here today to talk with us about his experience in Arkansas.

STATEMENT OF HERB SANDERSON, DIRECTOR, ARKANSAS DIVISION OF AGING AND ADULT SERVICES

Mr. **Sanderson**. Maybe I can deviate from the agenda for just a second to thank the staff here from Senator Pryor's office especially for the work they have done recently on the prescription drug area. Our State stands to gain a substantial amount of money in this area by saving the cost of prescription drugs to our Medicaid beneficiaries, and we really appreciate that because that is money that can go a long way for serving other people.

I want to address just some of the bullet points in my statement and I will summarize my testimony. The first two I have combined. That is the bullet points dealing with: Is AOA in a position to fill its analytical and educational role, and whether AOA is providing sufficient technical assistance to State units on aging and AAAs. In one word, I would say that the answer is no.

Over the years, I am concerned that the capacity of AOA has been eroded by loss of staff. In my testimony, I outline a series of questions that I suggest that the Committee or maybe the General Accounting Office might want to answer in order to compare the capacity of AOA as the aging population has grown while maybe their staffing and travel budget has diminished.

Let me say this, too. It is like a State Senator that used to be a prosecutor told me. He said: one thing I learned when I was a prosecutor is that people like law enforcement, but they don't like too much law enforcement. I guess that is the same thing I feel about AOA. I would like for them to have a capacity of technical experts and people that can assist us. I am not suggesting that we need an overpowering bureaucracy that just writes paperwork. I do think it would be great if they had various specialists that could provide technical assistance to States and AAAs.

A lot of this is being done now through the discretionary grants. There is at least one drawback to that. That is that once the grant is over, there is not residual capacity within the Administration to retain that expertise. For example, there used to be a long-term care center when there were long-term care centers in every region. Those centers are no longer funded. The people that benefited, the staff and such, are now gone in our region. They may have survived in other regions, but we lost that capacity of all the expertise that they built up over the years that they were the long-term care centers.

Another problem I have had is that on several occasions I have wanted to have the regional program director come to our State to participate in conferences or meet with various people, and he was unable to do that because there were simply no travel funds to do that. We even offered to pay his way but that is evidently a conflict of interest. I think it is rather pathetic when the regional program director cannot come out to the States at the invitation of the State director.

Finally, I have a specific suggestion to remedy some of this. That is, that certain language be inserted into the Act that gives the Commissioner full authority over the salary and expense budget to adequately administer the Administration on Aging. As I understand it right now, she does not have control over her own salary and travel budget that is appropriated to her. The people higher up in OHDS exercise that control, but I think the Commissioner ought to have that full authority.

The next point I want to address is whether the current position of the Administration on Aging within the Department of Health and Human Services is most advantageous to fulfilling AOA's role. No, I do not think it is. I think the Commissioner should be elevated to the position of Assistant Secretary.

As I understand the argument, probably why that has not happened is that the budget is not as big as some others. I think the issue is as big as any issue this country will face. We heard some demographic data presented at the beginning. This country is in fact aging. It will affect the entire fabric of our society, and I do not think it would be inappropriate to have somebody at the highest level of Federal Government in a position to help us steer in the course this country needs to go.

We certainly do not have the capacity at this time to deliver the services to meet the needs out there. The population is only growing, and we need leadership at every level, Federal, State, and local.

In terms of whether AOA can be more effective in improving the efficiency, coordination, and dissemination of data collection, I am concerned that we place greater burdens on local programs, area agencies on aging, and States in reporting data. Reporting data costs money.

Many times the local people that actually produce the data are tremendously overworked, and I think we should be careful in new requirements. I do think that there is a lot of opportunity to look at other data sets and make some analytical observations and extract information out of that. A lot of data is collected. I think a better job could be done in looking at what is already there.

The final point I would like to address is that of the Federal Council on Aging. I think their role could be vastly improved by assigning them with the authority to hold hearings throughout the country on various issues that effect the elderly. If they did that, I think their role would be much more meaningful.

Congress could also charge them with holding White House Conferences on Aging every 10 years. If that was done, we would not be in the position today where, as a State director, I have no idea whether or not we are going to have a White House Conference on Aging 3 months from the end of this year in 1991.

That concludes my testimony. Thank you.

[The prepared statement of Mr. Sanderson follows:]

TESTIMONY

ON

ADMINISTRATION ON AGING: MEETING THE CHALLENGE OF A GRAYING AMERICA?

PRESENTED TO

UNITED STATES SENATE
SPECIAL COMMITTEE ON AGING

PRESENTED BY

HERB A. SANDERSON
DIRECTOR
ARKANSAS DIVISION OF AGING AND ADULT SERVICES

ISSUE: **Whether AoA is in a position to fulfill its analytical and educational role, given limited resources and staffing;**

ISSUE: **Whether AoA is providing sufficient technical assistance to SUAs and AAAs in order to facilitate the operation of OAA services;**

The role of the Administration on Aging (AoA), contained in Title II of the Older Americans Act, is extremely broad and comprehensive. Full time equivalent (FTE) assets in AoA have slowly diminished over the years beginning since around 1973 when approximately forty (40) slots were transferred from AoA to staff the newly-established Office of Human Development Services. While appropriations have increased since 1973, the number of FTE in AoA decreased. The impact has resulted in a gradual, but steady erosion of staff with certain program expertise such as in nutrition, transportation, employment, etc. Without such specialists, it is difficult for AoA to analyze issues and assume an educational role. Particularly with other Federal programs and agencies underserving the older population. In addition, the dearth of such expertise diminishes and the quality of technical assistance that was once available to State and Area Agencies from AoA. As an alternative, AoA has been reduced to funding contracts or grants under Title IV discretionary programs to fill this vital role. Yet the result is that there is not a residual capability within AoA, once the grant or contract period has expired.

The availability of travel dollars for AoA staff has been seriously reduced over the last 10 years. As a result, on-site technical assistance has been seriously hampered. In many cases, when State and Area Agencies have offered to pay the travel and per diem of AoA staff to provide training or technical assistance, it has not been allowed. It is our understanding that this is only allowed where there is permissive language in authorizing legislation. Another potential solution to this problem is if the language were to be added to Section 201 (a) giving the Commissioner a line item in Federal appropriations with full authority over the salary and expense budget to adequately administer the Administration on Aging.

To further examine this issue, the Committee could obtain the following information:

- Indicate by year and amount, the highest and lowest number of full-time equivalents (FTE) within the Administration on Aging (AoA) since the program's inception.
- Indicate by year and amount the highest and lowest level of travel resources available to AoA to carry out its mandated administrative role since its inception.
- Since 1980, provide an estimate of the average number of trips AoA staff have made to State and Area Agencies annually.
- Provide the relationship between the AoA salary and expense (S&E) levels and programs funding levels (formula and discretionary grants) over each of the last 12 years. Indicate S&E as a percentage of program dollars for each year.
- Indicate the number of formal AoA memorandums of understanding and cooperative agreements between AoA and other Federal agencies over each of the last 12 years.
- Indicate the number of AoA FTEs transferred to the Office of Human Development Services since its inception in 1973.
- For each of the last ten years, provide the total dollar amount expended in salary and expenses in all components of OHDS (including AoA).
- What percentage of the above total annual dollar amounts devoted to salary and expenses over the last ten years was expended to support staff who worked directly for the Commissioner on Aging? For Commissioners of all other program units? For fiscal support services (OMS, OFOs)? For all other OHDS salaries and expenses?

ISSUE: Whether the current position of the Administration on Aging within the Department of Health and Human Services is the most advantageous to fulfilling AoA's charge;

The position of Commissioner on Aging within the Department of Health and Human Services should be elevated to that of Assistant Secretary. This action is necessary to enhance the cooperation and coordination that is needed among Federal agencies. The status and the visibility of the person who directs the Administration on Aging are critical factors when it comes to advocacy on behalf of older persons. Under the current organizational arrangement, the Commissioner is at a distinct disadvantage when she is negotiating with key Federal agencies. This recommendation that the Commissioner be elevated to the position of Assistant Secretary has considerable support from agencies that are involved with the expansion and the improvement of community-based care for older persons. It is clear to the aging network that the Federal focal point for older persons needs to be at a very high level if we are to achieve the lofty goals established in the Older Americans Act.

ISSUE: Whether and how AoA can be more effective in improving the efficiency, coordination, and dissemination of data collection;

I am concerned about requiring states to report new data. Data collection and reporting cost money. The AoA can access, rather than duplicate, systems currently "on-line" which address the social service needs of our target population.

The Series Computer Network of the Rehabilitation Services Administration is such a network system. The National Institute of Disability Research has funded the University of Oregon to set up the system for RSA's use. One of NIDR's research and training centers is specifically targeted to aging programs. AoA should examine the possibility of developing a more cohesive and comprehensive approach in facilitating data collection and the exchange of information by joining the existing system being managed at the University of Oregon.

Examples of specific RSA programs with a mutual clientele:

- Independent Living Program, Title VII of the Rehab Act, is a community-based program providing priority services to older disabled individuals. Part C of Title VII specifically targets services that the elderly blind.
- Projects in Industry has as one of its priorities in 1991 services to older disabled persons.

As a potential model, AoA could promote the use of the Series Computer Network through a joint Memorandum of Understanding with RSA. Once RSA is supportive of this collaborative effort, SUAs and AAAs could call the systems operator directly to be placed into the computerized network.

ISSUE: What is the role of the Federal Council on Aging? What should that role be?

The role of the Federal Council on Aging (FCA) could become extremely valuable if it were charged with holding hearings in various cities regarding the accessibility and performance of other Federally-funded programs that serve the elderly. Results, along with recommendations for corrective action, could be required in annual reports to Congress and other entities.

Additionally, the FCA should be charged with administering White House Conference on Aging each decade, thus precluding delayed decisions regarding implementation.

Mr. **Musselwhite**. Thank you very much. We appreciate your coming today from Arkansas and giving us that view from the point of view of a State agency on aging.

We will now move along to another level in the aging network, the area agency on aging level. Our next presenter is Mr. Edward Keenan, the Director of the Montgomery County Aging and Adult Services in Norristown, PA. I want to say a few words about his background.

Mr. Keenan is a native of Philadelphia and was educated in the city's parochial school system. He has worked as a direct service worker for the Philadelphia County Board of Assistance. He was a community organizer for the Lighthouse Settlement House. He was Director of the Catholic Social Services for the Diocese of Camden, NJ, and for the last 15 years, he had been the Executive Director of the Montgomery Country Office on Aging and Adult Services.

He told me before this meeting that he could not image anything more exciting—he is more excited today, I guess, than at any other time in his 15 years at the Montgomery County Office on Aging and Audlt Services. He is also a member of the Catholic Charities USA Commission on Aging and of the Strategic Planning and Funding Committee of the United Way of Southeast Pennsylvania.

I want to welcome Mr. Keenan at this time and ask for his remarks.

STATEMENT OF EDWARD J. KEENAN, EXECUTIVE DIRECTOR, AGING AND ADULT SERVICES, MONTGOMERY COUNTY, PA

Mr. **Keenan**. Thank you, Jim.

I would like to qualify that comment, Jim, since my wife is in the audience. The most exciting thing in my life is seated to my right. [Laughter.]

Mr. **Keenan**. Being a AAA director finishes second.

Let me begin by thanking especially the Members of the Senate Special Committee on Aging. I feel kind of flattered to be here today, to be invited with some very distinguished guests who are at various levels of government and in the private sector, all of whom obviously give a damn about older people. I feel like I am one of you in that sense, but I am also serving in a governmental role and I feel very strongly about the role that I carry, so I am pleased to be able to say a few things.

I do have some prepared comments. I will just try to summarize those comments. I would like to try to connect two points of view or two questions that were posed to me. One of those is dealing with the issue of coordination and the other is dealing with AOA's technical role.

For me, coordination at the Federal level does not have a lot of meaning. I am sure it does for AOA, but for all of our surrogates down at the local level, sometimes those memos of understanding do not mean a great deal. What does mean a great deal to me is what we are talking about in terms of coordination and what needs to be coordinated. What is it that all of us need to really work on?

For me, over a long period of time, I have recognized that there are a subset of communities within my particular AAA that I refer to as the natural care giving communities. It is where people naturally go for health and social services. It is in that context that I think we need to think about coordination.

I will say some more about that in a minute. Where I think AOA comes in is that I think they need to do considerably more. Very specifically—I cannot be so general as to address all of the TA that they need to provide. If, however, they are going to provide any kind of TA, they need to provide it in relation to coordination and look at the various kinds of options and ways in which coordination may occur at the local level and then share that throughout the country.

If I may suggest, there are a couple methods or ways of coordinating: One is in a formal way; and, the other is an informal way.

Let me just go back to our beginnings, the beginning of the area agency on aging. We were given two simple but very heavy mandates: to provide comprehensive services and then, somehow mystically, to coordinate those services.

What I learned from the very beginning is that as long as there was money and funding, as long as there was the Pennsylvania Lottery dedicated to older adults, comprehensive services are really possible, as long as the money is there. However, the second part, getting people to work together to try to develop a system of service, that is no small task. I struggled with that from the very beginning.

For over a 2-year period, I met individually with small groups of health care providers, especially, nursing home administrators and hospital social workers and hospital administrators and some of the HMO folks, and then the social service providers. Of course, what I saw was just what GAO said many years ago, namely, that there is indeed a fragmentation within the system. It seemed that there was not a great deal of information about what each service provider did.

Unfortunately, at that time, the health care community, especially, tended to be the ones pushing people into the nursing homes. That was also identified in the GAO study. I thought: what can we do about that? How can we change some of that direction?

Again, I brought everybody together and tried to pull together what they said. What was clear was that those people in these "natural care giving communities" who, in fact, are helping similar people needed to come together, to meet and to plan together. This is in contradiction to what some commentators say. They say: "the Older Americans Act is really only half a loaf." AAAs it has been stated can only coordinate services that they provide.

My value is that we need to do much more. If that is all we do, we are missing the whole health care system in the process and we are not really wedding and marrying two critical pieces of the community. We need to do more.

There are a lot of differences within the community. What I discovered, was that, I was the new kid on the block 16 years ago, there were a lot of health care folks around with various histories and professional roles and so forth. They had difficulty accepting something that I was putting out. I do not doubt that that still exists today. There really is a pecking order, as you all know, in the service system.

We really need to address those differences. What we need to do is find the common goals, find that we are working for the common needs of people in communities.

What I have suggested is axiomatic in any community; that older people are going to live more freely and thrive when the service systems are functioning in an interdependent way and see each other in that kind of close-connected way. Today, only a few States have a single State agency where they have more authority to give direction to various service systems, that is both the institutional and noninstitutional services.

What does that bode for AAAs? Where should we be? Well, I think—maybe it is because I have had some of that background—I thought it was critical that we needed to organize all the provider agencies, that we needed to bring people together, and I invested in that. I invested myself; I made some calls to key agency leaders; and, I helped bring people together. I reached out to the health care system and especially the hospitals, involving them in making calls to their peers.

What I have offered in my testimony is a series of activities that, in fact, have been happening for about 7 years in our county. In our community, there are four distinct groups that have met now for 7 years. They include: nursing homes, hospitals, health care agencies, personal care homes, home-delivered meals, you name it. The whole gamut of folks have been coming together into what we have called a long-term care consortia.

Those groups have been sustained by our office. We have funded staff to make them go. If there was no staff for the Senate Special Committee, the committee would not work. The same is true for these organizations. I learned that one long ago.

These four distinct groups are doing all of the things I have mentioned in my testimony. What they represent today is 200 agencies. Now, 200 agencies is power in a small community. Of course, if they all can agree on one thing, that is very powerful. What they have tended to do is agree on a number of things.

They have been very active. They have helped each other. They know each other. What I have suggested that the outcome of all this coming together is, is a climate that is very nutritive. It is very nourishing. People know one another. The attitude becomes one of: I am not going to take you on quite as much; I am going to do a lot more to work with you and to collaborate with you. These consortia have enlightened themselves, educated others, and transformed their communities into something that is very significant.

I would like to offer this consortia idea to AOA and say: this is exhibit A; this is one model. It is not the only model. What it is for me is the informal way of coordination. I don't have any power over anyone. In fact, these groups take me on from time to time, and that is part of the democratic process that I accept. They do have power and I respect them for it. I offer that just as one example.

Of course, the more formalized way of coordinating services is the role that is rarely touched upon in the Older Americans Act, which I think needs to be addressed much more fully. That is, the case management function. In Pennsylvania we call it care management.

The State unit on aging and the State department of aging have done wonderful work over the past dozen years, not alone, by the way, but in concert with AAAs. They have put together substantive forms with a prioritization aspect to it, and they have done that with us. It really does feel like a partnership. It is a critical role that we play for those who are chronically ill.

More recently, the Department of Aging has instituted pre-admission screening and services statewide after about 6 or 7 years of experimenting in some parts of the State. What they have done is to allow AAAs to coordinate at two critical points along the continuum: the one population who are chronically ill and need that coordination and those who are acutely ill. We are in fact diverting some people from nursing homes. What we are really doing is sustaining people in their own homes longer.

These two ideas of coordination—the one in a formal way is care management, the other idea that I mentioned, i.e., the long-term care consortia, is an informal way. Together, these two principles represent, in my judgment, the heart and soul of the Older Americans Act. It was what we all heard in the very beginning: we are going to try and help people stay in their own homes as long as possible. Well, that can be done in at least two ways—formally and informally.

Finally, I would like to just suggest, as one author wrote some years ago that, hopefully, some future reauthorization of the Older Americans Act will not only talk about the right to care but also the right to have that care coordinated so that it is appropriate where each client happens to be. Thank you.

[The prepared statement of Mr. Keenan follows:]

Testimony to
United States Senate Special Committee on Aging
at Workshop on
"Administration on Aging: Meeting the Challage of a
Graying America"
October 18, 1990
Washington, D.C.
By

Edward J. Keenan, Executive Director
Aging and Adult Services
Montgomery County, Pa.

Senator Pryor and members of the U. S. Senate Special Committee on Aging, may I express my sincere thanks for the wonderful opportunity to offer testimony at this workshop focused on reauthorization of the Older Americans Act in 1991.

My name is Edward J. Keenan. I am the Executive Director of the Office of Aging and Adult Services which is the Area Agency on Aging for Montgomery County, Pennsylvania. I have been in this role since the agency opened 16 years ago.

In reviewing the questions posed to me by your staff, I would like to address and attempt to link two of these questions.

First, on the issue of AoA's role in the effective "co-ordination" of Federal agencies, I would like to redirect that question and shift the focus, instead, to where I believe the concept of "coordination" really needs to take place, namely, at the local level or what I call the "natural care-giving community." Such a "community", whatever it's square mileage, is where older adults tend to go, naturally, to obtain health and social services when in need of such help.

Secondly, on the issue of AoA's technical assistance role, especially, as it may be directed toward area agencies on aging, I would rather see AoA extend a greater effort to assist AAA's to develop practical "options" and "models" for more effective coordination within every Planning and Service Area. To expend time and effort on "memos of understanding" between Federal Departments often, it appears to me, has little or no impact at the local level between their surrogates.

To support my perspective about refocusing the issue of coordination from the Federal level to the local level and how, vis-a-vis, AoA might better use it's time and fulfill it's technical assistance role, I will identify, conceptually, two methods of service coordination. Both professional activities, or methods I believe, are instrumental to the role of area agencies on aging and can be enabling functions to help AAA's carry out the second and more complex part of the Older Americans Act mandate to establish a coordinated service system.

Since beginnings are so very important, let me just digress a moment to the beginning of the AAS system and the Congressional direction as it may be found in the Older Americans Act.

From their inception in 1973, AAA's have been charged by Congress with two sustantive mandates: to develop a system of "comprehensive" services and, somehow, perhaps mystically, to assure that such a system is "coordinated." From the beginning, there was little in the Act by way of direction and only a smattering of examples of some early efforts at coordination passed along by AoA (by way of technical assistance) as to the "a quo", that is, the ways in which coordinated systems might be developed.

As time would affirm, AAA's initial role to develop a set of "comprehensive" services would be dependent, largely, on the availability of funding within each State and area agency on aging. The more critical function for AAA's of developing a "coordinated" service system is, I beleive, "all up hill," especially, in those States where no strong case management system exists.

In the recent past, some commentators have argued that the Older Americans Act goal and, therefore, AAA's role of promoting comprehensive and coordinated services is really "half a loaf" since coordination is limited to the non-institutional services funded by AAA's. Of course, for AAA's to ignore inclusion of health care agencies and institutional care providers in any coordinative effort would be leaving out critical parts of the whole "continuum of care."

On the other hand, one can easily see, for different reasons, why AAA's may want to shy away from more formalized links with the health and institutional care sectors. Prior the DRG's, these systems had not really sought out linkages with AAA's. Often, some in these systems saw themselves as professionally superior to the "country-like" AAA's, "health care" services while AAA's provide only "social services." Clearly, such systems have more money (translate, more power). Frequently, they have longer histories in the community than AAA's. And, for some, the influence of the "bottom line" may affect other values.

All of the above differences can represent major obstacles in any movement to bring together all parts of the continuum of care in any natural care-giving community. What will sustain any such organized effort will be recognition by professional care-giving services of their common goals and the common needs to sustain these organizations.

The quesiton, is of course, whether or not AAA's across the country see themselves as community organizers for this is what is necessary to bring together both the institutional and non-institutional sectors? Further, are AAA's willing to invest themselves and some of their resources to bring both sectors together and sustain that coming together for an indefinite time?

The extension of "seed" money by AAA's for such developments could bear much fruit. The on-going coming together of multiple health, social service and volunteer agencies in natural care-giving communities around the long term care needs of older adults is a mechanism that could foster healthy interdependent actions. Such a "consortium" of agencies would be a mechanism for:

- planning together;
- presenting in-depth information about each other's services;
- regularly researching the community's needs;
- creating services which had been unmet;
- establishing an agreed to standard referral forms;
- establishing seminars for professional development;
- educating the community about special needs;
- agreeing on position papers which support each other's needs;
- agreeing on position papers common to all their clientele;
- working with Legislative staff on the actual writing of long term care legislation;
- hosting health fairs in which all services are represented;
- making available emergency placements;
- printing/circulating thousands of informational brochures
- establishing a bi-monthly inter-agency newsletter;
- creating and running annual seminars for Family caregivers;
- hosting fund raising seminars;
- learning to use the media more effectively;
- opening up housing alternatives through effective advocacy;
- recruiting volunteers and direct service staff.

In describing all the above, I am, of course, begging the question. Seven years ago, our office, recognizing the polarization that existed then between and among care-givin agencies in both the institutional and the non-institutiona sectors took a giant stride forward for mankind with the ver capable partnership of a number of key health care providers.

Through this partnership, there now exists in 4 sub-areas of Montgomery County, Pa. 4 distinct groups consisting of representatives of: hospitals, nursing homes, home nursing agencies, home care agencies, home delivered meal programs, adult day care centers, senior centers, volunteer organizations, transportation providers, personal care homes, emergency hotlines, disaster relief agencies mental health clinics, housing agencies and telephone reassurance programs.

These 4 distinct groups are known as Long Term Care Consortia. Their identified function is to work together to coordinate services to older adults in need in their respective communities. Collectively, they represent almost 200 health, social service and volunteer agencies in our County who meet monthly or bi-monthly and are aided by very effective working Committees.

From their beginning, our agency has funded part-time staff to assist each Consortia to carry out their collective purposes.

After 7 years of formal organization, the 4 Long Term Care Consortia of Montgomery County have achieved all of the points (and more) which I identified above as possible activities for a LTC Consortia.

In essence, what the representatives of these 200 agencies have accomplished over the last 7 years is that they have educated themselves, enlightened their communities, transformed the climate among and between agencies so that it has become more nutritive and, continuously, advocate for unmet needs and new resources.

I offer the wonderful work of these 200 caring agencies as Exhibit A to the Administration on Aging. I suggest that it is examples like these 4 LTC Consortia and other models of coordination throughout the country which AoA staff need to become conversant with and to pass along to AAA's throughout the country.

Further research into how these, Consortia were developed which could be conceptualized and shared by way of a plan and instructions would be eminently more valuable to older adults in need than any memo of understanding between Federal agencies serving older Americans.

What I have described above is one way to "coordinate" services, that is, in an organized but "informal" method.

Of course, the more direct "formal" method of coordination, one which gives power and authority to coordinate and "turn on" or "authorize" services is what we all know as "case management." In Pennsylvania, we call this activity "care management."

I don't think I need to dwell on the efficacy of this process which includes: a substantive assessment, care planning, coordination of that plan, monitoring and reassessment activities. I simply want to point out that in keeping with the function of AAA's to develop coordinated systems that I believe that the coordinative function called "care management" belongs in house, that is, within Area Agencies on Aging. As one of my peers, Robert Dolson of St. Joseph, Michigan once pointed out: ".... experience indicates that the best systems are run by non-service providing agencies which can control the community care funding. It has proved to be a natural role for Area Agencies on Aging with successful state-wide systems run by Area Agencies on Aging in Arkansas, Washington, Massachusetts, etc." Care management is, as Bob has said: "... a realistic complement to our planning and program development functions."

In development of a sophisticated care management service as well as an equally sophisticated pre-admission screening and service program, Pennsylvania's State Unit on Aging truly has aided AAA's enormously in fulfilling it's coordinative role in a formal and fair way.

In summary, AAA Directors have, at least, two methods in which they can fulfill their function of developing coordinated service systems. The formal way is through care management. The informal way is through community organization efforts in bringing together multiple health, social service and volunteer agencies into a "long term care consortia." The essential aim of such an organization would be enhancement of interrelationships and to provide opportunities for coordination through engagement in the process of shared responsibility to bring about change.

If AoA is to carry out it's function described in Title II and "serve as effective and visible advocates: for older Americans within the Government's own system, I believe they need to invest their precious time to learn multiple ways and discover new "tools" so that AAA's can better carry out their function of providing comprehensive and coordinated services.

Hopefully, a future reauthorization of the Older Americans Act will one day declare it to be: "Public policy that supports the individual's right to receive care, especially, the right to expect that care will be so coordinated and organized as to assure that it is appropriate."

Mr. MUSSELWHITE. Thank you.

Mr. Keenan has added another block to our knowledge this morning. We started out with the Federal Administration on Aging point of view. We have also had a presentation from a State agency on aging, and now we have the perspective of a local area agency on aging.

We are going to expand a little more on the local level to look at some other perspectives as well. Our next speaker will help give us the perspective of an urban service provider.

Mr. Lewis Harris is the Executive Director of the Forest Hills Community House in Forest Hills, NY. He is Vice President of the New York State Conference on Aging, a member of the National Council on Aging, a member of the New York State Adult Day Services Work Group, the Chairperson of the Queens Coalition on Long Term Care, and the Co-Chairperson of the Citywide Coalition on Long Term Care.

He is a member of the State Advisory Council for the New York State Division of Human Resources and a member of the Board of Directors of the Nonprofit Coordinating Committee of New York. He is a member and board member of various other organizations in the city as well: Community Board No. 6 in Queens, the Queensboro Council for Social Welfare, the Queens Interagency Council on Aging, and others.

Now for the viewpoint of a local urban service provider, let me introduce Mr. Harris.

STATEMENT OF O. LEWIS HARRIS, EXECUTIVE DIRECTOR, FOREST HILLS COMMUNITY HOUSE

Mr. HARRIS. Thank you. I am really honored to be here. To be asked to participate in this workshop was a great surprise for me. When Anna Kindermann called last week, I think my first response was: I really don't know how the AOA impacts on the local level. I know that there is impact, but I am not sure what it is. After several days of research, I now know some of what does and does not happen, at least from a very local, urban perspective.

In New York City, as in most parts of our country, networks providing services to older adults are faced with the challenge of meeting the growing needs of the population 60 years and older and the special needs of the oldest elderly, 75 and older. Demographic studies predict a dramatic increase in this population over the next decade.

Minority elderly have also grown in numbers and represent a significant portion of the urban population. Approximately 3 out of every 10 older persons in New York City is a member of a minority group. Although they tend to be found among the younger elderly, their needs are often similar to those of the very old, indicating a lifetime of low income and poor health care.

Urban service delivery systems are struggling with serious issues of design and delivery of services to older adults. Minority access is an issue throughout New York City. Staff shortages and long waiting lists for services, especially in-home services, exist for most providers.

Preventative service dollars for adult day services, nutrition programs, and congregate services have eroded with the economy. The lack of, or weakness in, these services forces many older people into the long-term care system prematurely.

To carry out the basic mission of the Older Americans Act as defined by its 10 objectives, it is important that the Act reemphasize the importance of the Administration on Aging, the State units, and the area agencies as focal points for developing and maintaining a system of services nationwide. To do this on the national level requires coordination of diverse Federal initiatives and a cooperative working relationship of all Federal agencies impacting on the quality of life of older Americans.

This Act must ensure maximum flexibility at the local level if we are to provide services that meet the needs and conditions of individual communities. I cannot agree more with what Ed Keenan said about this. The community level, where the rubber meets the road, is where the services need to have flexibility and coordination. The reauthorization must ensure that local needs and conditions play an essential role in the design of the service system to allow a pliancy to respond quickly in creative and innovative ways.

In order to meet head on the current and anticipated needs of the older adult population, we must maximize the use of all available resources. Not surprisingly, this will require increased funding. For example, an increase is needed in Title IV funding for training, research, and discretionary projects programs. Over the past few years, several million dollars have been awarded to State and local provider networks for applied research. Through such funds, nationwide pilot projects and service models are instituted and trends are observed. These discretionary grants stimulate innovative and creative approaches to local service needs. Relevant cost-effective service systems are explored and developed.

This increase in applied research should provide the nationwide network with knowledge of the types of projects funded, the populations served, successes and failures within the projects, and other data. The AOA should be capable of observing and tracking national trends to establish best practices models.

It is important that the AOA collect data nationwide as it relates to the quality of life of older Americans. It is equally important, however, that the AOA have the capability to process and disseminate this data. Without access to the knowledge and experiences of the Federal findings, the aging networks at the State and local levels run the risk of being locked into a continuous cycle of reinventing the wheel.

Current staffing and funding constraints make it impossible for the AOA to adequately share the findings and data that come from State and local networks. We at the local level are not informed as to what the Administration on Aging has learned from its discretionary programs. The same is true of client and service data collected on the State and local level and submitted to AOA. Additional funds are needed to ensure the dissemination of data that will benefit the delivery of service to older Americans.

I have a few remarks about the Federal Council on Aging. In reading the act, it was very clear to me that there were five or six mandates of the Act to be carried out by the Federal Council. The

Act includes mandates to keep the President informed, to advocate for older adult issues, to hold hearings, and to disseminate information.

There is little awareness at the local level that these mandates are being carried out. To the contrary, I think that most of us feel that the Council is ineffectual in the performance of its duties.

If we are to address the needs of the increasing number of older Americans, the national network needs a Council that is proactive. The dissemination of information is also the responsibility of that Council.

If I read the budget properly, there is about $200,000 going to the Federal Council on Aging. If the dissemination of information and the other responsibilities that are mandated for the council are not being carried out, it would seem to me that the $200,000 could be used better at AOA.

In conclusion, the Older Americans Act has created a unique national network to improve the quality of life of hundreds of thousands of older persons by providing them with services. As a society, we all too often respond to crisis instead of effectively planning to avoid crisis situations. The challenge has just begun as the population over 60 years of age as well as those over the age of 75 has increased dramatically. We must plan well and we must be able to respond to the needs of this population.

Our ability to respond, however, relates to the efficiency of the system and the adequacy of the funding. We must look to the Federal Government to ensure that the resources will be there in the future so that aging Americans can obtain the services they need in their local communities.

I thank you very much.

[The prepared statement of Mr. Harris follows:]

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ADMINISTRATION ON AGING:
MEETING THE CHALLENGE OF A GRAYING AMERICA?

Presentation by

O. Lewis Harris
Executive Director
Forest Hills Community House

at a
Workshop
sponsored by

UNITED STATES SENATE
SPECIAL COMMITTEE ON AGING

at

Dirkson Senate Office Building
Washington, D.C.

October 18, 1990

My name is Lewis Harris and I am the Executive Director of The Forest Hills Community House. The Community House is a multi-service settlement house located in the borough of Queens in New York City. As a settlement house serving all age groups, we not only provide a wide variety of congregate and in-home services to the older adult population of our community, but also have the opportunity to develop programs and services that foster intergenerational contact. I would like to commend Senator David Pryor and the Senate's Special Committee on Aging for conducting this workshop in preparation for the forthcoming reauthorization of the Older Americans Act. This act is a critical piece of legislation that should be sustained, strengthened, and enhanced to provide expanded services to the nation's growing elderly population.

Over 1.3 million men and women 60 years of age and over are living in the five boroughs of New York City. It is estimated that more than 430,000 men and women over 75 years of age and approximately 130,000 of those are 85 and over reside in the city. The Borough of Queens alone is home to well over 400,000 people over the age of 60. This group comprises 20% of the Borough's population, 30% of New York City's total older adult population. Were the Borough of Queens not a part of New York City, it would be the nations fifth largest city based on land mass and population. The increase in the very old throughout New York City is due to increased longevity. Recent studies predict that by the year 2000, more than 100,000 Americans will live to be 100 years of age, a figure three times the current number.

Minority elderly have also grown in numbers and represent a significant portion of the urban population. Approximately three out of every ten older persons in New York City is a member of a minority group. Although they tend to be found among the younger elderly (the group 60 to 75 years of age), their needs are often similar to those of the very old indicating a lifetime of low income and poor health.

In New York City, as in most other parts of our country, networks providing services to older adults are faced with the challenge of meeting the growing needs of the population 60 years and older and the special needs of the oldest elderly, 75 years and older. Urban service delivery systems are struggling with serious issues related to design and delivery of services to older adults. Minority access is an issue throughout New York City. Staff shortages and long waiting lists for services, especially in-home services, exists for most providers. Preventative service dollars for adult day services, nutrition programs and congregate services have eroded with the economy. A lack of or weakness in these services forces many older people into the long term care system prematurely.

To carry out the basic mission of the Older Americans Act as defined by its ten objectives, it is imperative that the Act reemphasize the importance of the Administration on Aging, the State Units, and the Area Agencies as focal points for developing and maintaining a system of services nationwide. To do this on the national level requires coordination of diverse federal initiatives and a cooperative working relationship of all federal agencies that impact on the quality of life of older Americans. The recommendation of the National Association of Area Agencies on Aging, that the Act be amended to elevate the position of Commissioner of the U.S. Administration on Aging to Assistant Secretary status within the Department of Health and Human Services, is sound. In addition to increasing the Commissioner's control over program administration, operations, and budget it would give the Administration on Aging greater recognition and stronger input into all areas of the federal government that effect aging and thus strengthen the aging network's advocacy role at the federal level.

Although I encourage strenghtening the status and role of the Administration on Aging, I am concerned that it not become too highly bureaucratized. This would have a negative impact on the flexibility of service design, result in encumbered service delivery, and cancel gains made by the stronger role of the Administration on Aging.

Maximum flexibility at the local level is necessary if we are to provide services that meet the needs and conditions of individual communities. The reauthorization must ensure that local needs and conditions play an essential role in the design of service systems to allow the local network a pliancy to respond quickly in creative and innovative ways.

In order to meet, head on, the current and anticipated needs of the older adult population, we must maximize the use of all available resources. Not surprisingly, this will require increased funding. For example, an increase is needed in Title IV funding (training, research, and discretionary projects and programs). Over the past few years several million dollars have been awarded to state and local provider networks for applied research. Through such funds, nationwide pilot projects and service models are instituted and trends, observed . These discretionary grants stimulate innovative and creative approaches to local service needs. Relevant, cost effective service systems are explored and developed. This increase in applied research should provide the nationwide network with knowledge of the types of projects funded, populations served, successes and failures within the projects, and other data. The Administration on Aging should be capable of observing and tracking national trends to establish "best practices" models. It is important that the Administration on Aging collect data nationwide as it relates to the quality of life of older Americans. It is equally important, however, that the Administration on Aging have the capability to process and disseminate this data. Without access to the knowledge and experiences of the Federal findings, the aging networks at state and local levels run the risk of being locked into a continuous cycle of reinventing the wheel. Current staffing and funding constraints make it impossible for the Administration on Aging to adequately share the findings and data that come from the state and local networks nationwide. We, at the local level, are not informed as to what the Administration on Aging has learned from its discretionary programs. The same is true of client and service data collected on the state and local level and submitted to the Administration on Aging. Additional funds are needed to insure the dissemination of data that will benefit the delivery of services to older Americans.

The addition of other parts to Title III has expanded the network's ability to reach out and serve other populations, such as individuals with special needs and those suffering with Alzheimers and related disorders. Emphasis and visibility is also given to the diverse needs of the older population. However, adding parts to the Act without increased funding to carry out the provisions of the Act puts the Area Agencies and local providers at risk. We lose credibility in our communities as we try to address a broad range of needs with such inadequate resources.

I would also like to address the role of the Federal Council on Aging. The Act mandates the Council five responsibilities in addition to periodic reports to the President:

1.advise and assist the President on matters relating to needs of older Americans;

2.review and evaluate Federal policies to appraise their value and impact on older Americans;

3.serve as a spokesperson on behalf of older Americans by making recommendations to the President, the Secretary, the Commissioner and to Congress with respect to Federal policies and programs affecting the aging;

4.inform the public about the problems and needs of the aging by collecting and disseminating information, conducting studies, publishing results and issuing publications and reports; and

5.provide public forums, hearings, conferences and other such meetings for discussing and publicizing the problems of the aging.

There is little awareness on the local, urban level that these functions are being carried out. To the contrary, it is felt that the Council is ineffectual in the performance of it's duties. The absence of discussion or planning for a 1990 White House Conference on Aging at the nationl level is but one example of this. The Council appears moribund. If we are to address the needs of the increasing number of older Americans, the national network needs a Council that is pro-active

In conclusion, the Older Americans Act has created a unique national network to improve the quality of life of hundreds of thousands of older persons by providing them with services. The challenge has just begun as the population over 60 years of age, as well as those over the age of 75, increase dramatically. We must be able to respond to the needs of this population. Our ability to respond, however, relates to the efficiency of the system and the adequacy of the funding. We must look to the federal government to ensure that the resources will be there in the future so that aging Americans can obtain the services they need in their local communities

Mr. MUSSELWHITE. Thank you for that view of a direct service provider in an urban area.

To finish our panel presentation, our final speaker will be Sidney Murphy, the Executive Director of Preston County Senior Citizens, Inc., Kingwood, WV.

He is a licensed social worker in the State of West Virginia. In addition to being the Executive Director of Preston County Senior Citizens, Inc., he worked previously as a social worker for the Region 6 Area Agency on Aging, and was also a paralegal for a private attorney.

For 4 years, he was President of the West Virginia Association of Directors of Senior Programs, and continues to be a member of the executive committee of that organization. He has been extremely active in agencies on aging in West Virginia. I will not attempt to read all of the ones that he is currently involved with or has been involved with in the past. I will just mention a few of them.

He was a member of the State Advisory Council for the West Virginia Commission on Aging, a member of the West Virginia Continuum of Care Task Force, and he received a reward for helping a transportation system, the Preston County Rural Transit System, in 1982, to not go out of business. It is very expensive servicing a rural area. There are a lot of problems with transportation, and I know that must have been quite a challenge.

We would like to welcome you today and ask you to give us a view from the perspective of the rural service provider.

STATEMENT OF SIDNEY L. MURPHY, EXECUTIVE DIRECTOR, PRESTON COUNTY SENIOR CITIZENS, INC.

Mr. MURPHY. Thank you, Jim.

Mr. Chairman and members of the Committee, I want to thank you for the opportunity to be here today. Before I start let me say that I am not going to follow the written testimony as much as I am just going to talk with you a little bit. Before I start my talk, there are a couple of things that need to be said.

Every level of the aging network is understaffed and underfunded. What I am doing at my local level will not necessarily work for everyone. The difference in administration of AOA funding from one State to the next is amazing, as I am sure some of you have picked up here right at this table.

In view of the financial status of this country and the increasing need for services, we must all look for the most cost-effective method of continuing quality services to the elderly. As a rural aging provider in West Virginia where funding for services is minimal, Preston County Senior Citizens has found that effective coordination and centralization of services has immensely aided an increasing service accessibility.

In recent years, as money continued to decrease and needs increased, we at the local level realized that if we were to continue services, it had to be done with what service dollars were there. As a result, we took a hard look at all service providers and the services being provided, regardless of client demographics. With an open mind, we proceeded to streamline services.

Although this aided in continuing services and increasing some services, aging dollars do not begin to meet the need or fill the gaps. Many counties, not only in West Virginia but across this Nation, do not need four different agencies providing transportation in one county, three or four agencies providing in-home services, et cetera.

Taking a lead role, our agency worked and continues to work toward service specialization among providers. When dollars are being distributed among too many services or service providers, you tend to lose the capability to provide quality services.

As presented in my written testimony, you can view our efforts to coordinate services for the elderly utilizing one agency as a focal point for a comprehensive service delivery system. Although our focus is the 60-plus population, we have coordinated services so as to get the maximum for our dollars.

A couple of examples of this coordination are: whereas we were running vans to transport senior citizens, we now run those vans to provide transportation for Valley Mental Health clients, sheltered workshop, blind, III(c) nutrition, transporting in-home service providers, and delivery of homebound meals. Whereas Title III(b) dollars and minimal donations were solely supporting the elderly transportation program and we were just transporting senior citizens, a typical van run now consists of picking up mental health clients, for which we are reimbursed $1.25 per client, and stopping at the center to pick up meals to distribute to homebound elderly on the way to pick up the seniors to go shopping, for which we are reimbursed 20-cents per mile.

After the meals are delivered and while the seniors are at the nutrition site, the driver then goes to pick up employees, in-home care providers, and takes them to work. Opposed to our having to reimburse five or six vehicles for mileage, they are transported there to work. At that point, the driver goes back to the nutrition site, picks up the seniors, and transports them back home. She then goes to work with a different hat as an in-home service provider for the rest of the day until she is done. Then she picks up the other in-home service providers and returns them home.

At that point, the transit system picks up the Valley Mental Health clients that we took over earlier that morning and returns them in the afternoon. Coordination can work.

Another example is in regard to our health services. Prior to this year, the senior center had a full-time nurse and a case manager. Preston County, however, is fortunate to have a hospital located in our county. To make a long story short, we now contract with the hospital for nursing services, which saved us $6,000 per year and increased the quality of services. We now share a geriatric case manager, saving our agency $12,000 per year. We are working together on a community care program with emphasis on geriatrics and the hospital provides the nursing and health services while the senior center provides the social services.

Home health ceased to exist as a separate entity and moved in under the auspices of Preston Memorial Hospital. Again, we were able to reduce costs but increase services. This is but a couple of examples, but the list does go on. Basically, we have taken four agencies and specialized services.

I firmly believe that this coordination must be done at the Federal level. AOA should take the lead and look at al social service dollars and the many possibilities in coordinating these services. For example, Older Americans Act moneys fund chore services, housekeeping, legal services, and ombudsman services. Department of Health and Human Services dollars fund chore services for the elderly and adult protective services.

In our county, we are in the process that will be completed by the end of December of transferring all chore service cases from the Department of Human Services to the senior center, so that all 60-plus individuals will receive services directly out of that one agency. After this, we are going to be looking at adult protective services to do the same for the elderly.

There is no doubt that without coordination in our county, agencies would be reduced to nothing with continued decreases in funding. Coordination, unlike most activities, does not require a lot of money. It only requires time, and the big issue is forgetting about turf and focusing on need.

It should not matter who does what, but who can do it best for the least amount of money. Aging serivces are the best buy the Federal Government is getting for its dollars.

In West Virginia, we are currently undergoing a reorganization. Through that reorganization we are hoping to specialize service delivery for seniors statewide, much like our county is operating.

One of the barriers that we have run into and one of the differences from State to State is that the majority of our funding in West Virginia no longer comes through area agencies. Area agencies, of which there are nine, fund very minimal, only III(b) dollars, of which I get $54,000 of Federal money. We actually work with $1 million. The rest of the money comes down around the area agency.

That leads up to why I recommended changes in the Older Americans Act in the last page of my testimony. I said that the Older Americans Act needs to allow the States the capability to change the organization or structure of area agencies as long as the State meets the requirements of at least one area agency.

Currently, area agencies have to be de-designated and do not allow for change where coordination of communications could be improved. Years ago, there might have been a need for nine in West Virginia. Today, each county has a senior provider located in that county who is providing all the direct services for elderly. All III(b) funding comes straight through the area agency to that provider. It is not bid out in West Virginia.

Under reorganization in the State right now, all the money is coming through to these 55 providers, and the nine area agencies are still there, but the Act provides no way to restructure or reorganize. Some flexibility needs to be looked at there.

Some other things that we in West Virginia feel should be looked at are: the Act should allow aging programs the ability to charge for services on a sliding fee scale. Some are able to pay for services, yet the Act only allows for donations.

Thirdly, the Title III(c) nutrition bidding process should allow a waiver in rural areas where competition is nonexistent. An example: in Preston County this year, the program was bid out three times. On the third time, a contract was really just negotiated with a provider. The reason for that is that the bid packet was 500-600 pages and the small amount of money did not make it worth doing. In essence, the entire bid process in that instance was a waste of time and money,

Also, Title III(d) funds should be consolidated into Title III(b). In West Virginia, we sit and wonder why new titles are created for the aging dollars when—I get about the largest amount of III(d) moneys, $1,000 per year—and it has to be tracked separately, reported separately, and yet it is providing the same services as III(b).

That is basically all I have unless anyone has any questions. Thank you.

[The prepared statement of Mr. Murphy follows:]

Preston County
Senior Citizens Inc.

Testimony for
Senate Special Committee on Aging
October 18, 1990

Submitted by:
Sidney L. Murphy
Executive Director
Preston County Senior Citizens, Inc.

I welcome this opportunity to address the Senate Special Committee on Aging. It is indeed a privilege and an honor to provide you with the concerns and recommendations from the perspective point of a rural aging services provider. As indicated in the invitation, I will address the issues presented to the extent I can and will focus my oral presentation on data needs at the local level and most importantly, the need to coordinate services at the service provider level. Also, attached you will find a listing of suggested changes needed in the Older American Act.

Issue 1 - Whether AOA is in a position to fulfill its analytical and educational role, given limited resources and staffing;

Comments - Given the service reporting system, does AOA have adequate information to determine needs addressed with service dollars? Communication of 60+ needs at the local level to the federal level consistently receives the response of limited resources and the chance to do more with less. Repeated recitations of the amount of dollars available in proportion to funding invested in social security, medicare, and medicaid for 60+ does not address issues of need for support to adequately maintain independent living. I know at the local level the aging programs have more unnecessary reporting procedures than any other grants we work with. Most of the resources available at this local level are what we as local providers share with each other. Speaking for myself and I'm sure many others, I am not aware of what educational priorities and goals AOA has. The only training dollars we have any use of is through Title V. I am not sure that AOA is in a position to do the job that needs to be done, due to limited funding and resources. I feel that this has hindered aging programs as we have experienced a trickle-down effect, receiving very little information regarding what is available from AOA and how to tap in to what resources are available. Due to this, many local aging programs have been forced to expand into other areas of social services in order to continue services to the elderly population.

Issue 2 - Whether the current position of the AOA within the Department of Health and Human Services is the most advantageous to fulfilling AOA's charge;

Comment 1 - Currently, the state of West Virginia is going through a restructuring of state government. The West Virginia Commission on Aging has always been free standing and this year was placed under the West Virginia Department of Health and Human Services. This has proved to be on of the best moves I have experienced since being involved with this aging network. Immediately a medically-based community care program was established for in-home services and we are being reimbursed for medicaid eligibles. This offered immediate expansion of services. We are now in the process of receiving all 60+ chore service cases from the Department of Human Services and this will be completed by January 1, 1991. The availability of increased resources and training was welcomed by all local service providers. I would think that the current position of AOA would be advantageous due to increased availability of coordinating resources and training. This has certainly proved to be the case in West Virginia. However, I feel this is just the beginning of coordinating services.

The investment of health care dollars needs to be scrutinized. Partnerships between health care providers and in-home / community-based support providers need to be facilitated not only for addressing current shortfalls in continuity of care, but in preparation for an increased demand which will surely overtax and overwhelm the system as is exists today.

An example of this is that in West Virginia the development of additional licensed skilled and intermediate beds has ceased. In order to maintain operation, short-term facilities will more readily serve the existing insured skilled patient and the private pay intermediate care patient, thus creating an increasing shortage of institutional beds available for the chronically ill and permanently disabled. Persons requiring 24-hour health services and personal care need the availability of community coordinated based and in-home support services.

Comment 2 - In Preston County, the Preston County Senior Citizens and Preston Memorial Hospital have committed their resources and services coordination to focus on individual needs. As a result, during the first six months of 1990, acute care admissions for Medicare patients was up 40 %, re-admissions for 60+ patients during a 20 day period following discharge were down, patients follow-up office visits were kept, and overall patient health status has improved.

The single-point of entry to health and support services at the local level has proven to benefit both consumers and providers. Yet the efficient implementation of this system is often hampered by incongruent and restrictive regulations among various federal programs and their short-term solutions to reduce program costs. Coordination of funds to address health maintenance and promotion, income assistance, housing, and transportation needs to focus on care of the individual and be perceived as an investment, instead of designing restrictions to reduce costs and liabilities.

In essence, I would think that AOA would be in a prime position to work with the Department of Health and Human Services to better coordinate all aging services through one central focal point.

Issue 3 - Whether AOA is providing sufficient technical assistance to SUA's and AAA's in order to facilitate the operation of OAA services;

Comments - Technical assistance in West Virginia is very poor in relation to the amount of dollars that are channeled through. This reflects poorly on technical assistance provided by AOA. Direct service providers are more capable of providing technical assistance as those of us who have been in aging programs for several years are more able to relate to the problems experienced in providing OAA services. Area Agencies in West Virginia have repeatedly said that they do not receive funds to provide training. The West Virginia Commission on Aging may hold one training session per year. As a result, in West Virginia, the responsibility of training has fallen on those of us at the local service provider level. I feel one of the problems with aging programs is that the bulk of aging dollars is used to maintain status quo instead of addressing current and future needs. Technical assistance is desperately needed but I think it is lost due to AAA's becoming more involved in direct services, thus creating competition between AAA's and local service providers, and leaving less time for AAA's to provide technical assistance as more and more they are administering programs. This is especially the case in West Virginia and because of this what technical assistance is provided is usually negative as opposed to being positive, creative, and supportive.

Issue 4 - Whether and how AOA can be more effective in improving the efficiency, coordination and dissemination of data collection;

Comments - AOA could be more effective by seeing that all providers know what is available in the AOA library. For example, program profiles, demo projects, experiments, educational materials, life-time studies/ generational studies, etc. AOA should be in a position to effectively influence coordination of research, education, and services affecting the 60+ population. AOA's influence tends to only reiterate special interest group presentations of realities. AOA's service dollars are too restrictive and too little to actually fill gaps in the existing service structure.

Issue 5 - What steps might AOA take in order to assure more effective coordination with other federal agencies;

Comments - Preston County Senior Citizens has effectively coordinated services with various other agencies to become a single point of entry for all 60+ individuals in Preston County. We provide Title III-B services consisting of transportation, client finding, referral, case management, escort, nursing assessments, instruction and training, material aid, housekeeping, chore service, letter reading and writing, and respite care and receive only $ 54,840 in Title III federal funds. Because of increased coordination of services the Title III-C nutrition services are being provided by North Central Community Action covering three counties, which prior to this year, we administered. One year ago many agencies were having transportation problems and Preston County was at risk of losing its transit system. Preston County Senior Citizens stepped in and, I'm proud to say, saved that system. We now provide all transportation services in Preston County serving Valley Mental Health, Sheltered Workshop, Department of Human Services, the general public, and all senior citizen transportation. Our transit budget is $ 158,000. This year we received $ 450,000 in additional grants and continue to improve transportation services through coordination. We are also coordinating geriatric services with Preston Memorial Hospital (called Project Goldencare) which embraces full range primary care for the elderly, assessment of each elderly person's functional family / community support system and maximum enhancement and support for home-based caregivers upon whom they depend for on-going care. We also coordinate services with the Department of Human Services utilizing a community care program providing services to both medicaid and non-medicaid individuals. As mentioned earlier we are also in the process of taking over all 60+ chore recipients from DHS. Preston County Senior Citizens also has 17 Senior Companions providing in-home services, this program being funded by ACTION through Region VI Area Agency on Aging. We also train senior citizens for employment via the Title V training program. We are now in the process of planning for a Preston County Social Services Center, where all social service agencies in Preston County will be housed in one central building allowing for a "one-stop shopping" center for services.

I would encourage AOA to look at all agencies where 60+ individuals are being served and look at coordinating resources and funds through one central focal point. All agencies providing health care, education, transportation, and social services should be looked at. For example, as long as I can remember, I have asked why 16-B-2 transportation and III-B transportation could not be documented the same way. Currently, we utilize 16-B-2 vans to transport seniors and III-B funds help purchase gasoline and we have to send monthly reports to both funding sources. Due to the different counting mechanisms, each driver must keep two sets of records and two reports on the same trips reflecting different counts which must be compiled monthly. This is something that I think AOA could easily change through coordination.

In closing, I feel AOA needs to review at the entire realm of services available to the 60+ population, take a hard look at what other agencies are doing, and push for a coordinated service delivery system, standardizing reporting forms, sharing information, and revising program regulations to support healthy, independent life-styles as opposed to screening persons out of eligibility.

Recommended Changes in the Older Americans Act:

1) The Older Americans Act needs to allow the States the capability to change the organization or structure of Area Agencies, as long as the state meets the requirements of at least one Area Agency on Aging.

2) The Act should allow aging programs the ability to charge for services on a sliding fee scale. Many are able to pay for services, yet the Act allows only donations.

3) The Title III-C Nutrition Bidding Process should allow a waiver in rural areas where competition is non-existent. For example, in Preston County the program was bid out twice before anyone bid and then a contract was negotiated as there was only one agency interested. In the other five counties within Region VI in West Virginia, there were no competitive bids as current providers continued with the programs, yet bids had to be done. The bids submitted were 500-600 pages long as required by the Area Agency. The entire bid process was a waste of time and money. The bid process definitely needs reviewed.

4) Title III-D funds should be consolidated into Title III-B. It makes no sense to create yet another funding source separate from Title III-B when the funds are providing the same services. In Preston County we get $ 1,000 in Title III-D which has to be tracked and reported separately from Title III-B. Most counties in West Virginia receive less than this. The amount of time and paperwork required to differentiate Title III-D from Title III-B is certainly not cost effective.

Mr. **Musselwhite**. Thank you very much for that presentation. I thank all of our panel members once again for enlightening us on all levels, Federal, State, and local in terms of your experience and your ideas. I think you have laid out many challenging issues for us this morning and have once again demonstrated the incredible diversity that we find in the aging network. I am sure that will be a part of the discussion that we have this morning.

We are right on time. Thank you all for keeping us on schedule. This is the part of the program when we open up to the audience and ask for your participation. Your participation is really crucial to the success of the workshop. We would like to encourage you to either speak into one of the microphones that are located near you or come up to the microphone on my right. Once again, please identify yourself by name and where you are from.

Are there any questions, comments, observations?

Ms. **Benoit**. I am Moya Benoit with the Subcommittee on Human Services and I have a question for Carol.

I was just curious as to whether you knew when the fiscal year 1992 grant announcement notices were going to be going out?

Ms. **Crecy**. We are trying very hard to get it out earlier than we have in the past. You are talking about discretionary grant announcements, right? We are in fact working on it right now and we would like to get it out earlier than we did last year. We have our fingers crossed, basically, but we hope to issue the announcement sometime in November.

Ms. **Kindermann**. I am Anna Kindermann with the Senate Special Committee on Aging. I just want to know what the panelists think as to whose role should it be to ensure that those on the front lines, the service providers, are receiving the information that they need; that it does trickle down the network to them. Whose job is that? Is there any sort of tracking done? I just wanted to get your comments on that if you have any.

Mr. **Harris**. I personally believe that there is a lot of national data that has to come down to us. On the local level when you are working to build a public/private funding mix to provide services with very scarce public dollars, it is important to have knowledge of trends and knowledge of what is working and what is not working to get a national view. I think the data needs to come out of the AOA.

Ms. **Crecy**. If you noticed in the testimony, we did say that we are working with the Census Department on 1990 data. There is a group of State and area agencies and other representatives working with us to determine the subject matter of the data tabulation, the level of geographic detail, and basically how to disseminate the information we obtain. We think this effort will provide State and area agencies with key data which will be useful to them.

STATEMENT OF FRED LUHMANN, ADMINISTRATION ON AGING

Mr. **Luhmann**. If I may, please—I am Fred Luhmann from the Administration on Aging.

The question of reaching local service providers with this kind of information is complicated from a number of standpoints. One: there is no national list available anywhere of all the people who are providing services to older people at the local level. Secondly, at least on an initial count, you are probably talking in excess of 10,000 or as many as 15,000 such provider agencies.

The cost of replicating and distributing materials to each of them and the maintenance of any kind of credible list is something that would bear serious consideration. The possibility of distributing material to providers through State and area agencies seems a little bit more feasible. Certainly, providers should have necessary information, but whether it is a practical and cost-effective approach to try and do that through a national distribution requires some serious deliberation.

Mr. KEENAN. I would like to also reemphasize that point. I think that AOA passes along to the States and the States pass along to AAAs a great deal of information. I think AAAs are, perhaps, where the buck stops. If we do not do something to make sure that Lewis and the various providers know and can sort some of that out, then, that is a failing for us.

The point that I was making earlier about the various agencies that come together—I mentioned in my testimony that some of these agencies have put together substantive little newsletters. They get information from me all the time and I copy that to four people. That information then gets out to 200 people by reason of the fact that the group is working together and has this kind of a mechanism.

I cannot stress enough the importance of a "mechanism" to disseminate information. There is a mechanism within government. We in goverment need to work closely with the private sector to make sure that there is a mechanism there for it to happen.

STATEMENT OF GLEN DUNBAR, PENNSYLVANIA DEPARTMENT OF AGING

Mr. DUNBAR. I am Glen Dunbar with the Pennsylvania Department of Aging.

To pick up on this point of getting the information out—that is one of the most important roles that we see for the Administration on Aging and probably one of the most significant shortcomings that we see at the present time. We feel that the Administration on Aging is definitely understaffed. It has been losing staff for the past decade and it needs the resources to get information out to people who need it.

Basically, the way that we perceive the Administration on Aging is similar to a manufacturing plant or a business in the private sector that lacks a sales force. The Administration on Aging is producing good products. It produces good ideas and, through the discretionary research program, it produces good research. It produces good model programs, but it does not have the sales force to go out there and actually put those tools and those good ideas in the hands of individuals who can make effective use of them.

If we could make only one change in the approach of the Administration on Aging it would be to sell that notion of establishing a sales force so that it can get the information out. Thank you.

STATEMENT OF LARRY RICKARDS, NATIONAL ASSOCIATION OF AREA AGENCIES ON AGING

Mr. RICKARDS. I am Larry Rickards, National Association on Area Agencies on Aging.

Carol and Fred, you have heard a number of suggestions about increasing TA and coordination and so forth. Apart from funds, or including funds, what are some of the other factors that are inhibiting your abilities to move information more fully?

Ms. CRECY. I believe we are doing the best that we can with the resources that we have. I do not want to overplay the importance of the interagency agreements, but I think they have been very important for us as a means of providing technical assistance and coordination at the State and local levels.

A piece of paper does not, by itself, make any real difference. An agreement does send a message out that we are concerned and that we are working together. However, it is what the parties to the agreement actually do in promoting collaboration that is most important.

For instance, through the coordination between the Department of Transportation and the Department of Health and Human Services, a best practices manual on human services transportation was developed and made available to State and area agencies on aging. It is the kind of document which can be used at the State level to show providers what works and what specific transportation services will be effective in that particular State.

We gave money to Texas and Ohio to have workshops to use that manual as a basis for service planners and providers to come together and decide: in our State, how is transportation for older persons going to work, and how can we make it work at the local level? The reports from those workshops will be coming out soon. They will be given to others to look at and to apply in their own situations.

Technical assistance and collaboration are very complex. There are a lot of things going on. We are trying, with the resources we have, to strengthen TA and collaboration at the community level.

Mr. RICKARDS. A follow-up to that question—there has been discussion about your having lost numbers of staff, both at the central office and out in the regional offices. If you had an influx of funds for some miraculous reason, would you then be able to hire staff, or have some of those positions been permanently lost or shifted to other departments or agencies either within HHS or permanently lost?

Ms. CRECY. If your question is if we had additional funds, would we hire more staff—the answer is yes, certainly we would.

Mr. RICKARDS. Would you be able to do that right away, or would you have to go through OPM or some larger entity?

Ms. CRECY. There is a process, obviously, in the Federal Government for hiring staff, particularly looking at the comments from some of you about hiring staff from the network, which means going outside of people who are currently in the Federal system. Yes, we would have to go through OPM to have an open announcement. We are looking forward to being able to have that opportunity to get people who have, for instance, experience in nutrition, or an ombudsman who has worked at a local or State level who could come into the Administration on Aging and provide us with that kind of expertise.

Ms. **Danielson**. I am Nancy Danielson with National Farmers Union. We are the sponsor for Green Thumb.

I think my question would be directed toward Mr. Sanderson and Mr. Keenan or Mr. Murphy.

How good do you think the coordination is between the programs that are providing training and employment for older Americans in your agencies, and if that coordination is not currently sufficient, what can be done to improve it?

Mr. **Sanderson**. If you are talking about Title V, as far as I know, it is working pretty well. We meet periodically with all the Title V grantees and work on the equitable distribution plan—I believe that is what it's called.

I usually hear about things that do not work well, and I have not heard about that. I can only assume that it is working well. The JTPA program in our State is working pretty well at the present time, although it is threatened by some changes.

Mr. **Murphy**. I might add that in West Virginia, with the Title V program, we have really had no problems with training employees. Those employees are placed in different facets of the community. However, I have noticed an increase in the last couple of years—JTPA training programs popping up—and they seem to be in competition. That has probably been the only problem area I have seen in the last couple of years in West Virginia.

Mr. **Keenan**. In our county, we have been lucky because we have had a couple of staff that have stayed around for a long time, both in JTPA and Title V. They work very closely with the private industry councils and the employment service.

A couple of our staff have some unique experience. One of them is 74 years old and has been riffed out of a job a couple of times, so he understands a lot about people being put down because of age. He is a wonderful counselor as a result.

In terms of coordination, that has been going pretty well. I think we have done fairly well in our corner of the State.

STATEMENT OF JOHN OLINGER, SUBCOMMITTEE ON HUMAN SERVICES, HOUSE SELECT COMMITTEE ON AGING

Mr. **Olinger**. I am John Olinger with the Subcommittee on Human Services, the House Select Committee on Aging.

To go back a minute to the dissemination question—earlier this year, in fact last month, the subcommittee had a hearing on data dissemination and research dissemination under Title IV in which we had testimony from the General Accounting Office. I think that at this point we are very much aware that people pay attention to what is going on; they are looking for better ways, people in the field, obviously, to find out both what is going on in terms of program information, but also in terms of the results of research.

One of the other things that we highlighted at that hearing was the recent AARP Public Policy Institute study on data collection on minority participation. I guess that one of the things I would like to follow up on—Mr. Sanderson specifically mentioned about not more burdensome reporting requirements—but one of the shortcomings that is very apparent to us in Congress as we look at trying to evaluate things like targeting and other issues like that is that we do not seem to have good solid information on which to make these judgments.

I guess my question is twofold: how much of your time, all of you, as people who are involved with the Older Americans Act, do you spend in terms of trying to keep up with the requirements that we put on you in terms of reporting data, and what are your reflections on ways in which the system can be improved so that we get the sort of information that we really need to figure out what is happening in terms of when we recommend certain changes or what changes we ought to recommend?

Mr. **Sanderson**. You know the burden is rather significant. Where the data has to be collected from the Title III programs is where the services are delivered.

Just look at the buying power of the Title III dollars. I think that by the AOA statement, it has diminished some 30 percent in the last 10 years.

Site directors and people that work in the senior citizens centers are very strapped for time. Yet, they are collecting a tremendous amount of information. Many of these people come to the center five times a day. They may get transportation, congregate meals, socialization, or some type of other service which you have to record.

We are a small State, and the volume of data that you have to record is just tremendous. One way trips, counting transportation, is a large task. I think there is a burden on that.

One of the things that struck me about 4 or 5 years ago is: within a 60-day period, I got five letters from other States saying they were trying to develop an automated management of information system. That was 10 percent of the States right there within that period. I do not know how many others were trying to do it that did not write to ask what other States had done.

It seems like that in my 13 years of experience, I have yet to see somebody come forward with a system that is specifically designed and works well across various States to collect and help make this process easier. That is something that I think somebody ought to look at.

We have been doing this for a long time, and I just have not seen any one great system that will meet everybody's needs. It seems like that would be money well spent. To me that is the only way we can go.

The other thing to consider, like Sidney said, the Older Americans Act dollars are now kind of the small funding stream in a lot of these programs. These people are also reporting and accounting for a lot of other dollars. You need to keep that in mind when you talk about it. It is just not the Title III dollars that are involved.

Mr. **Murphy**. I would also like to address that question.

Of all the operating funds that we receive, the Title III dollars require the most paperwork. The deadlines are tighter. They just are the most time consuming and the largest amount of paperwork. Something desperately needs to be done.

The Older Americans Act needs to look at some kind of flexibility for reporting. An example is—Herb mentioned transportation. We have 16(b)(2) vans. We report to 16(b)(2). We get III(b) dollars to buy gasoline for those vans, and we have to report to Title III. We have to keep two separate reporting systems, counting units in different ways for the same trip on the same day and time.

For 16(b)(2), they count units one way there. Every time the person gets on the van, it is a unit. Under Title III, it is one way. For a driver to have to keep two sets of reports and then we have to compile two sets of reports for the same run is ridiculous. Something desperately needs to be done with Title II reporting procedures.

Mr. **Keenan**. The Older Americans Act dollars in Pennsylvania represent about 30 percent of the dollars, so 70 percent of the dollars are State dollars. Yet, the 30 percent are heavily regulated. Those time frames are very tight.

When we started out and had 12 or 15 providers, there was a certain anxiety level. Now there are 70 providers. There is increased anxiety in getting these reports in and so forth. Since AOA's money represents such a small proportion of the whole, maybe just in terms of the reporting, backing off a little would be a good choice.

Mr. **Rickards**. Can you estimate how much it costs you to fulfill these data requirements?

Mr. **Keenan**. We have a small staff who work assiduously. The costs are large to our own staff, but the costs are spread throughout the system.

One of the rubs between ourselves and the providers is those short time frames in getting reports in to us. That sometimes hurts them and maybe if that were a little easier, the relationship would be a little easier, too.

STATEMENT OF ANNA MADISON, TEXAS SOUTHERN UNIVERSITY

Ms. **Madison**. I am Anna Madison from Texas Southern University in Houston, TX. I have a question I want to ask Carol.

How frequently do you evaluate your priorities under the coordinated discretionary funds program?

Ms. **Crecy**. Built into each of the discretionary grants is a process for monitoring and evaluating what is being done. I think that recently there has been an effort to bring certain types of grants together. We convene what we call cluster meetings or cluster reviews. For instance, if we have several grants in the area of health promotion, we use the cluster meetings to look not just at one grant but at a group of related grants to find out what the information is being generated and how that information can be effectively used.

That is done at various stages throughout the process. At the beginning, we are looking at what the grants are trying to achieve, and at the end, we are looking at the products that are coming back and how that information can be used. We are looking at ways to better communicate and put together a package, really, of the information that we have so that it is more useful to people in the field.

Ms. **Madison**. The reason I am asking is because I reviewed for the program and had colleagues who have reviewed for that program. One of our major concerns is the lack of evaluation on certain types of programs that have been in existence over a period of time where you could really tell whether or not that program is really effective and which methods are best for the policy goal or objectives or whatever you are trying to achieve under that particular program.

One of our concerns is that the Older Americans Act does not provide for a mandate that says that you must review those program, must evaluate, or provide the money to do it. In other words, it would be an additional thing that you would have to do with the limited funds that you already have to provide for the kinds of things that older Americans need. There is a major need to evaluate those programs when you sit on a review panel and you see projects being funded over again that you know from the network in your local area are programs that are not effective and those people are not coming close to what your mandate is asking them to do, but yet there is no systematic evaluation, not to throw the program out but to look at what is working and what is not working. That is one of the things I would like to see included in the Older Americans Act, a provision, a legislative mandate for evaluation periodically of those programs, and for that evaluation to be used to improve the system.

Ms. **Crecy**. I misunderstood your question. You really asked me a different question.

Older Americans Act funds may be used for program evaluation. The Older Americans Act established an evaluation setaside of one-tenth of 1 percent of total funds, or $300,000, whichever is less. That is not a lot of money to do an evaluation. Therefore, when it is used, it generally is a very small scale study.

For 1991, we are looking at taking some of the Title IV discretionary money and using it for some other kinds of assessments and evaluations of the Title III program, but not of the grants that come through under Title IV Program evaluation. It is a very important area and one that we need to give more attention to.

STATEMENT OF ENID KASSNER, AARP

Ms. **Kassner**. I am Enid Kassner with the American Association of Retired Persons. My question is directed to those of you who have expressed some concerns about the burdensomeness of reporting requirements.

What I would like to know is how you believe that, without a reporting requirement, you demonstrate that you are in fact meeting the goals of the Older Americans Act, particularly for example, with regard to service to minorities, low income persons, and other vulnerable elderly?

Mr. **Sanderson**. I do not think that anybody said we should not have to report that information. We just said that it is burdensome to do that.

If you go to a local senior citizens center and talk about reporting minorities and low income—well, people come in and out of the program. You either have to have a computerized system, and I think very few service providers, at least in rural areas that I am aware of, have computerized systems. If you have to manually count cards, and every time you go back and add another factor to it, then you have to manually calculate that stuff.

I cannot emphasize too much how the demand for these services has risen. Really, I do not know that we have to look at the data about what we are serving to say that we need to be doing more in this area. I think we can look at the demographics and go out and look at the people who need the services.

Look at the census data in terms of the poverty rate. We have the third highest poverty rate among elderly in the United States in our State. I do not think we need to count a lot of data to know that we need to serve and that those people have a need.

I am not saying that we should not have to report data. I just think that people need to be aware that every factor you put in there means that somebody is going to have to collect and collate that data. Service providers do not have a lot of capacity to do that.

It is easy for me at the State level. All I have to do is take eight reports from eight AAAs and add them together and put them in an envelope and send them off to AOA. It is not easy to do at the service provider level.

We are trying to help them, not with AOA dollars but with State general revenues, to implement a computerized information system. I know the power of data. As I said before, the AOA dollars are a small part of our aging program.

My emphasis is with the State legislature to try to get more money. We have gotten a lot more money out of the State legislature than increases from AOA.

I know the importance of data. I just wish people could be familiar enough to understand the frustration when we go to a service provider and say: tell us this, this, and this.

Mr. **Harris**. I said that I really did not know how AOA affected the local provider. That is because in New York State much of the moneys for delivery of services to older people comes out of State tax dollars and city tax levy moneys. All have their own reporting requirements, so by the time a service provider like myself receives guidelines for reporting back to the State and city, it can be quite monumental.

We have been encouraging the city and the State to consolidate the reporting requirements. I don't know what portion of the reporting goes back to AOA, but it seems to me that AOA could take a leadership role in encouraging the State units and the local area agencies to review and consolidate their reporting requirements.

In government there is a tendency to add on instead of incorporate. The result is quite bulky. As service providers, we suffer from duplicate reporting.

STATEMENT OF DAN QUIRK, NATIONAL ASSOCIATION OF STATE UNITS ON AGING

Mr. **Quirk**. I am Dan Quirk with the National Association of State Units on Aging.

This discussion of reporting is not a new one. It seems to me to bring up an important point here. What we have always heard from the providers, AAAs, and State units is that there is more reporting with the Title III moneys than almost any other service programs that exist in America today. Yet, in Washington, what we always hear from people in this room and others is that we don't know who we are serving.

Something is amiss here, it seems to me. Is the issue perhaps not that we are not reporting enough, but maybe we are not using the data correctly; that we are not disseminating that data correctly?

I am wondering whether you want to comment on that. I know from what you have said here that you all feel that you are reporting enough to the area agencies, to the States, to the Feds, as to who you are serving, what kind of services, how much it costs, but somehow, there is still the sense in Washington that we don't know who is being served with the Older Americans Act.

Why do you think that is, and how do you think we can solve that problem?

Mr. **Harris**. While doing research for this panel, I did make contact with the State unit and the Area Agency on Aging and it appears that data is supplied to AOA but little of the information collected is disseminated back.

Mr. **Murphy**. When I started out, we used to track 60-plus. Today, we track 65-plus, 75-plus, socially, maybe low economically, minority, and the list just keeps growing.

I have no idea where the information is going. Hopefully, we assumed it was being required by someone and was supposed to be getting there. If it's not——

Agreeing with Herb and Lew, we are definitely not saying that we do not want to report. It is just the amount of information required per client. If those reports are that necessary, then someone should be providing the funding to hire somebody to keep up with those.

Mr. **Sanderson**. I agree with Dan. I think we do report a lot of information. We report information by age, race, sex, how many meals, they get. We have quite an extensive data base.

I guess it is unclear what information people think is not being reported that they want. I am kind of confused about that because I agree from our perspective that we do report. We have an intake form that must have 30 items on it that is collected on every client. I would like to hear what data is needed that is not being reported.

Mr. **Harris**. I am very much concerned that there are models and service ideas being tested throughout the country with Federal dollars, and the only time I get any sense of what is going on outside of New York City is when I go to a National Council on Aging conference and then you don't always get a sense of a national trend.

I have the responsibility to create and locate funding for services to older people in Queens. It certainly would help if I knew what was being tried elsewhere; what failed, and what worked. If tax dollars are going into a delivery system, then somehow we should be able to package the results and get them back to the system or part of those moneys are wasted.

Ms. **Crecy**. Well, we think that best practices material is very useful. I think we have done some. We certainly could do more.

In terms of the basic data information, it is collected in AOA, aggregated, and there is an annual report that goes out that has everything that comes in to us being reported back out to you in terms of how many people are being served and what kinds of services are being provided. Again, it is aggregated national data, and that is reported back out on an annual basis.

In terms of the more specific best practices, I think we can do more of that. We are looking at trying to do more of that.

Mr. LUHMANN. Let me add a footnote in terms of two points that have already been made here. One is that Federal agencies other than AOA also in some instances, like 16(b)(2), have their own reporting requirements, so it is a two-sided coin.

If the point is that AOA should accommodate its reporting to 16(b)(2) or to any of a multitude of Federal services that are funding things, then there is a question of who coordinates and who works together to come up with some agreed upon consensus as to what the reporting data will be. I think that is statutorily as well as administratively a large task, not solely something that AOA could accomplish on its own initiative.

Secondly, I think a point made here also by more than one speaker is that a significant amount of the funds going to the area agencies and down beyond them to the service providers does come from State dollars. If State reporting requirements are established for the use of those dollars, then AOA is really not in a position to alter those State-imposed requirements or necessarily to bring conformity among each of the various State requirements.

It becomes a rather complex puzzle to fit the pieces together. At best, AOA is one player in terms of what it can or cannot do within the Title III requirements for reporting. There also, that is a matter of what the statute does or does not require. The instrumentality for doing that is within AOA's hands, but not the content necessarily of the particular elements.

Everybody, I think, is interested in getting data useful for productive programs and other uses. I do not think that anyone has yet found the magic wand that I think somebody was looking for. We certainly are as interested as anyone in working with all concerned for that purpose.

Carol mentioned that the Commissioner will be convening a State and area agency task force to look at this. Again, the purview of that group will be colored in some way by the investments they have in already mandated systems within their individual States and local communities. Where it goes from there, I think, is a very complicated and perhaps time-consuming issue.

STATEMENT OF ANTOINETTE SAMUEL, PRINCE GEORGE'S COUNTY DEPARTMENT OF AGING

Ms. SAMUEL. I have one inquiry. I am Antoinette Samuel from Prince George's County Department of Aging.

If the report requirements are aggregated and reported out yearly, what is the rationale or the basis then for requiring it on a quarterly basis at the local level? Perhaps that requirement or the relinquishment of it would alleviate some of the pain of reporting. Is there a reason that it is quarterly as opposed to annually?

Mr. **Luhmann**. If you are speaking about AOA reporting, it is annual unless the States or local communities set other guidelines.

Ms. **Samuel**. I would be interested to know if in other areas the reporting requirement is quarterly.

Mr. **Harris**. In response to the concern that there are State requirements and that AOA cannot demand what the State require in their reporting—I think there has to be an attitude or focus established. In the Federal view, the AOA is the center of the wheel. From there it radiates to the State which has to address the needs of the AOA. It would then be an important suggestion from AOA to the States that they incorporate Federal reporting requirements in their reporting forms used by service providers.

I can tell you that the providers will advocate to streamline the reporting on the State and local level.

It seems to me that the service initiative must begin at the Federal level creating a national focus in addressing the needs of the older population. We look to Washington for that. We look to AOA for that.

Mr. **Murphy**. In West Virginia, we are required to report monthly. The reports are due by 4 o'clock on the fifth working day after the last day of the month. However, the State only reports back to us with a statewide total quarterly.

Mr. **Quirk**. I think that Fred brings up another interesting point here in how we look at the data that comes out nationally in terms of the Older Americans Act. The Older Americans Act now is about half the budgets of State and area agencies. We are all happy about that because it shows some commitment from State governments and county governments in putting money into services for older people.

I think, though, that often we look at the data that comes in through the Older Americans Act as being in a vacuum, as if this is the only data that is somehow supporting older people, when in fact, I think that State and area agencies at the local level use the Older Americans Act to compliment those State dollars and those county dollars on which we in Washington do not have any information in terms of who is being served or not served by those other funds.

I am wondering whether it might be useful for us at some point in time to take a look at those State dollars and those local dollars. I do not mean to develop some sort of massive reporting system, but some sort of sampling perhaps to look at who is being served by the other 50 percent of the funds that are in fact flowing through the aging network that tend to be State and local money. I think we would learn something about who is being served and who is not being served in the Older Americans Act as well.

Mr. **Musselwhite**. I just wonder in terms of the issue that you raised about the other programing, State and local programing and other Federal programing as well, not only in the area of data collection and use but more broadly, we see many new services in the 1980's and State agencies and area agencies are working with many different programs as are service providers.

With multiple data requirements and other requirements with this sort of situation today, one that may become even more diversified in the future in terms of other programing and other requirements, what role should we expect of the Older Americans Act and the Administration on Aging in working with these programs, services, data collections, and so on? I wonder if members of the panel would take a shot at responding to that question?

Mr. **Keenan**. Our agency is not only an aging agency, but for a number of years now, we have been serving low-income adults. It was interesting to hear Herb Sanderson because we have the same agency name, aging and adult services. We moved in that direction because we thought there were plenty of people under the age of 60 who looked, characteristically, like those who were 62 or 72. Of course, there are other kinds of needs of low-income people.

In Pennsylvania, it was a missing link. It was a missing piece of the pie. There were advocates for MhMR and child welfare and aging, but not for the population in the middle.

We took that function on. So, what that means for us is that we have a very complex set of reporting requirements. AOA's requirements, as the gentleman suggested earlier, are only a part of it, but it is a very complex part.

The issue for me in reporting is the short time frame. For the Department of Public Welfare in Pennsylvania, we have fewer reporting requirements. We have to report some of the same kinds of characteristics about people but the demands are considerably less. There is a lot more of a grace period in terms of when these statistics are to be reported. The State Unit on Aging, responding to AOA's requirements, is in a hurry, which adds to the pressure of the job.

What was said earlier is that AOA's requirements seem to be the most demanding of all, yet AOA dollars represent only 30 percent of the whole. That is an irony. You know, who is driving whom? Who is adding to the stress?

In our system it is stressful enough having these multiple requirements in Pennsylvania because of this preadmission screening program and because of a number of other State programs like the Family Caregivers Program. They are all unique separate programs with unique requirements and we are all going nuts trying to computerize all of that.

It is an enormous task. It has become increasingly complex, and we really do need the help of AOA to put it into perspective.

Mr. **Sanderson**. Specifically, they could work with other Federal agencies to come up with common service definitions and an agreement. Like with UMTA, why should one Federal agency require you to report a round trip and another one to report a one way trip? Maybe some changes like that could be done at the Federal level to make it easier to meet everybody's requirements.

STATEMENT OF AL STEINCERRUCI, GAO

Mr. **Steincerruci**. My name is Al Steincerruci from the General Accounting Office.

One issue that has come up in the past is the issue of minority participation rates. There is also some controversy about whether that is a real decline.

I have a question directed then to those at the local levels. Do you have any sense in your areas whether or not minority participation is truly declining? If so, what do you think are the reasons behind that?

Mr. **Harris**. In New York City there is certainly an initiative to increase access for minority populations. My observation is no, it is not declining. To the contrary, it is probably picking up because of the focus in outreach to minority populations.

It is a very simple concept but something that took time to establish. That is, if you are working with a minority population that is not English speaking, you must have staff that speaks the language of the population.

When we began to focus our staff toward the population we were serving, and then identified cultural differences, etc., it made those services more accessible and more comfortable for the minority population. I think we will continue to see a growth of services to minority elderly in New York City.

Ms. **Kindermann**. There is something that I would like to ask. That is, what types of data are needed at the local level? What kind of information would you like to see come back to you?

If you have these reporting requirements and you are giving out information, you would hope that somehow that would come back to you in a useful form that you could use to help you provide the services that you are providing. Is there someone that could speak to that issue?

It is not just what we need here in Congress. It is what you all need on the front lines as well that is particularly important.

Mr. **Harris**. At the local level, we certainly are identifying problem areas in service design all the time. The information on those discretionary projects is critical, but it is also important for me to understand where else in this country the situation is similar to the one I'm addressing. That gives me an area of focus, it helps me understand commonalities of problems and solutions that we have not identified in the Northeast. I just think I can plan better and I can provide better service if I have a sense of the whole.

Ms. **Kindermann**. Almost a sense of best practices or things that are working——

Mr. **Harris**. Yes, it's important for me to know how other areas of the country are dealing with minority access or information on service systems in cities with large over 65 population or a significant older old population. How are these issues or needs being addressed in other urban settings?

If the information is available, it can benefit our programs and is good for us to be able to use it.

Mr. **Murphy**. Probably one thing I would like to see is a breakdown between urban and rural because the needs are so different at those two levels that when we see a report coming out with overall services, we really cannot take from that much information to help us. We look at those and we may think: why on earth would we need that service here? The number may be huge and it may be a service that is very much needed in urban areas. We would like to see a breakdown of what services are provided where, rural versus urban.

Ms. **Braunstein**. I would like to follow up on a point that Sidney made before about counting trips, the way that UMTA makes you count them one way and somebody else makes you count them another way. Are there any other examples from anybody here in the group about Federal reporting requirements that actually conflict or perhaps areas where you see that different Federal agencies all the way down are imposing duplicative kinds of reporting requirements?

Mr. **Sanderson**. What we have tried to do in our State is take into account the flexibility we have and move toward one system. What we have done is move toward our Medicaid system a lot because that is where the big bucks are. So, in terms of our State revenues and our policies, we have State revenues that we put into the program and we try to model those after the Medicaid because that is where the dollars are.

I cannot say how much off the top of my head—Medicaid does not pay for home-delivered meals unless it is under a waiver. In that case, we designed our waiver to match the Title III home-delivered meal benefits. We have tried to match them up as much as possible.

I am probably a poor person to answer that question. I think that the service provider probably has a better perspective because they do deal with a lot of the energy, weatherization, and looking at different types and definitions of clientele. They would probably have a better idea about that.

STATEMENT OF CARL FENSTERMEKER, GAO

Mr. **Fenstermeker**. Carl Fenstermeker from GAO. I have a question to kind of follow up on what has been discussed over here.

To what extent do you people at the local and State levels find that the information that you are being asked to collect is actually useful for your own purpose, and what kind of information are you being asked to collect that you could really live without and you don't need?

Mr. **Harris**. In New York City, we are in the middle of an initiative to streamline paperwork and reporting.

It is important for local providers to build some type of working relationship with the oversite agencies to look at reporting requirements. Sometimes you get two separate requests for information, but they are essentially requesting the same information.

The process of streamlining reporting requirements from various government agencies is a very difficult one. Every level of government needs certain types of information. As I said before, government too often makes changes by adding rather than revising and incorporating.

We face a big task in New York City, so I am assuming that an undertaking such as this on a national level is just as difficult. We have been in the process for a year and a half, and I see more time to be spent before we come out of it with a satisfactory result.

Mr. **Murphy**. In West Virginia we have a form where the only information required on the form, basically, is the person's birthdate to make sure they are available for the services, name, and address. Then below that, there is a section that says that the person does not have to fill out the following information if they do not want to, so they do not sign a release, but there are like 52 questions under that per person as far as what type of dwelling they live in, whether they rent or own, whether they wear glasses, whether they have a cane—it goes on and on, getting into income, et cetera, and we are expected, if it is not filled out, to go and fill it out with our best guess. At that point, I wonder how much good that information really is doing.

Mr. **Keenan**. I would have to compliment our State unit, again, not because someone is here, but they have done quite well in terms of sorting that out. Some of the information that Sid mentioned that may be relevant for a care manager is information that we think is critical. On the other hand, there is other information in terms of the centers, the use of the meal programs, that is considerably limited.

What they have also done, too, at the State level is to try and coordinate and suggest that we collect information that may be used again in the State-sponsored programs. I think Pennyslvania has done a lot of that coordination.

As I said, also, they worked with the AAAs. We have a strong AAA association, and we have worked a lot with the State around those issues that Lou was addressing, and they have been responsive.

The dilemma, of course, is that as the years go by, as Lou also said, things get added on. We have to go back to the well sometimes and say: take it easy guys; let's change this or that. There is a nice feeling between the State and AAAs that has helped a great deal. Again, what they pass along, too, is what is required of them.

Mr. **Dunbar**. If I might add, something else that has happened in Pennsylvania in terms of trends is that there is a very clear trend toward computerized reporting systems. Not every area agency on aging in Pennsylvania has a computerized system at the present time, but almost all do.

Certainly in the near term future, all will. I think that resistance to use of technology, resistance to getting into computerized reporting systems, will ultimately work to the disadvantage of the aging network if that resistance exists.

Perhaps that is a role that AOA can play, promoting that technology and working within the system to develop a hardware contract and data systems approach that would be workable and cost-efficient throughout the Nation.

Mr. **Murphy**. I would like to also address that issue because it has definitely been a problem in West Virginia.

We computerized 3 years ago. We were told that after 1 year, we could drop the manual system. To this day, we are doing both and the reports have yet to match.

At some point, there definitely needs to be technical assistance that is getting through the State level on down to the local because there absolutely is none in West Virginia. As a matter of fact, the competition for what few dollars are there is so fierce that you lose any kind of valid technical assistance that possibly could be given.

We have had a time with reporting. The computers at this point have doubled our work at the local level. We are now keeping computer reports plus manual just to try to get them to total out, so I think technical assistance is a big area that needs to be addressed.

Mr. **Olinger**. I would like to ask a question. A number of you have indicated support for upgrading the status of the Commissioner on Aging to the level of Assistant Secretary, and in addition, I think that some of you specifically mentioned that so that there would be control, the Commissioner would have control of her own budget in terms of salary, travel, and all those sorts of things.

I guess my question is in two parts. One is: what experiences have you had that sort of led you to realize that the lack of control of the budget is indeed a problem and has an impact on what you try to do? The second thing is: what are your expectations about if this were to happen? What are your expectations about what is going to be different, either better or perhaps maybe worse about it?

Mr. **Sanderson**. The first part of that question—I think that one year and maybe twice, we have not had assessments done by our regional office on our agency or on our program. Now that is not the most exciting thing I look forward to in this job, but I do have turnover in staff and I do find some comfort in having outside people coming in, looking at us, and saying: you're doing this okay; you're not doing that okay, rather than waiting 5 years down the pike to come in and say: you've been doing this wrong; we are going to recoup for the last 5 years.

Again, I do not want an overburdensome monitoring and evaluation arm from AOA, but I do think that is an appropriate role as it is for us to go out and look at the AAAs. I do think it can be constructive and preventive, so I think they need to have at least enough travel money to effectively do that.

In terms of the AOA, I think some of it is just like our Nation's Capital here. I think that some of it is symbolic. Having somebody at the highest level is important just for that perspective. I think that with that type of elevation—in fact I think somebody's written testimony mentions that same experience at the State level—once you take the programs out of some bureaucratic level and raise them up in visibility, that tends to be viewed positively and I think things happen after that.

It just seems to carry more credibility, more influence, and I think it would be a positive thing.

Mr. **Keenan**. I think what the role of the Commissioner of Aging may change inasmuch as the people want it to change. In Pennsylvania, there was a movement toward trying to establish a separate unit on aging, a cabinet level post. That did not come about because the legislators were all in favor of it. They were not.

What occurred was that when they were considering it and the votes were in doubt as to which way it would go, the people showed up in numbers from Philadelphia and Pittsburgh and did not let the legislators out of the building until they voted their way. There is an organizational theory about power not being transferred. It is usually taken, and in that case, it was.

I am not sure whether elevating the power of the Commissioner is going to mean that much more for older Americans. It certainly would represent a certain status, but I do not hear, at least not in very strong terms, organized older adults coming out to advocate for this. I don't hear AARP doing it—maybe they do—I don't hear such an outcry in the way it was handled at our level.

Ms. **Madison**. There is another thing, too. I believe you were saying the Commissioner now sits in the policymaking meetings with the Secretary now. That is primarily because of his peference, isn't it, to have her there? If you institutionalized it by making it an Assistant Secretary post so that it could become a permanent part at that level, would that make any difference?

Ms. **Crecy**. There was a change in the Older Americans Act in 1987. As a result of that change, the Commissioner on Aging now reports directly to the Secretary. That was interpreted as requiring that she not only talk to the Secretary on policy matters, but that she serve as a full member of the Secretary's senior staff. That has happened and was happening prior to Dr. Berry's appointment as the current Commissioner, so it is not just something that is happening because Dr. Sullivan is the Secretary.

Mr. **Musselwhite**. At this time, I wonder if we could go back for a second—we have heard a lot of discussion and comments about assistance that State and local agencies would like to get from the Administration on Aging in various activities. I wonder if we could go back and ask people to think a little bit in terms of the limited resources that are available and, if you are a State or local agency looking for assistance from the Administration on Aging, what would be the one or two types of assistance that you would be looking for? If you were in a position to talk with AOA about your most pressing needs that they could be of assistance to you with, what would those needs be?

On the other side, the AOA side, I wonder if perhaps we might get some indication of what things might help you to provide that sort of assistance. Would anyone like to express a view on those issues?

We have talked about technical assistance, data collection, dissemination of research, and demonstration results, and about salesmanship.

Mr. **Dunbar**. The most pressing question for us, if we were to go to AOA and ask one question of technical assistance, I think we would say: help us get a Medicaid waiver. That means working HCFA and sorting through all the Medicare regulations and actors to help us get a Medicaid waiver to expand our services.

It is a complex piece of work. I do not think that AOA can give us much help there.

Mr. **Sanderson**. We went through about 2 years ago—we did not have a waiver in our State—and we began the process. It was one of those things where if you don't have a 2176 waiver, you have to start from scratch. You can't go to anybody in your State and do it. It is a great effort; that's true.

We had to go to other States and other Medicaid agencies around the country. It would have been very nice to have access to the Administration on Aging that was expert in Medicaid waivers. Still, in negotiating with our local HCFA office about the waiver, it would have been very beneficial for us to have somebody, just as they have somebody in Washington, on the phone that may have a lifetime of HCFA regulations, if we could have had somebody on AOA that knew them just as well as they did, they maybe could have presented different views on interpretation of the regulations and policy.

STATEMENT OF JOANNE KEISER

Ms. **Keiser**. I am Joanne Keiser with the State of Maryland.

We would be interested in learning more about getting assistance from AOA on private sector initiatives and how to have that compliment our funding picture. We would like to compliment our services through the private sector.

Ms. **Samuel**. If I had the opportunity to speak, I think I would ask AOA to either provide us, through technical assistance or specialized training, how can we at the local level be more effective transportation managers, particularly as the graying of America occurs and particularly for those that are over 85 that may require specialized transportation?

How can we efficiently provide that service? It becomes, in my mind, actually managing a business of providing a transportation service. How can you do that in the most effective manner?

Mr. **Harris**. Training is a service for which we would also look to AOA. On the local level the training dollars have become very scarce and I assume that AOA has the same problem.

As we identify a changing population and new dimensions of the older population, we have to keep our staff trained and ready to meet new challenges. There needs to be some assistance from AOA for that.

Mr. **Murphy**. If I had one thing, I probably would go with what several of you have already said: knowing what dollars are out there, what else is available that we can utilize with aging programs? We see no information as to what other Federal programs have aging dollars available or what grants are out there or where to really look for those other dollars.

Mr. **Musselwhite**. That should be easy to respond to. [Laughter.]

Ms. **Crecy**. I would like to be able to give you all of those things.

We have a mammoth task in trying to meet the needs of all different levels, the State level, the area agency level, the service provider level. We, ourselves, need to be more efficient in how we get the needed information out to the field, and in how we collect it.

Again, I want to go back to the interagency and intraagency agreements that can enable us to provide some of the things that you are asking us for; for example, through this agreement with UMTA, we can become more knowledgeable about what is going on in terms of 16(b)(2), the agreement also helps us identify what we can do to work together with UMTA that will make a difference at the local level.

We have had several roundtable discussions hosted by the Commissioner. In the next year, there will be others. For instance, we have had a roundtable discussion on cost sharing, one on minorities, one on elder care. We find that this has been an invaluable way of getting information from the various levels because usually we have representatives from States from, area agencies, from service providers, as well as from national organizations.

It is a format which we will be continuing to use to get the kind of feedback that we need in order to be responsive to your needs. Communication is in fact a two-way street. I would encourage you, when you have ideas or when you need help, to contact the nearest regional office on aging—there are 10 regional offices across the country. They are there to serve you. If they are not doing that, let's try and see what we can do to make them be more effective and more responsive to you.

If you have questions and concerns—I know that some of you do not hesitate to write to the Commissioner on Aging and offer your suggestions. I am opening the door for others of you to do the same.

I think that this is something that we all have to work on together. By working together, we will be able to make a difference.

Mr. **Musselwhite**. Are there any additional comments in terms of things that might be done to assist the Administration on Aging to remove barriers?

Mr. **Harris**. There has been little discussion of the Federal Council on Aging. I really do not know how to impact on it. I'm concerned about the five mandates in the Act.

Is there a representative here from the Federal Council who can discuss this?

I am concerned that we have heard nothing about a 1990 White House Conference on Aging. I am not trying to put you on the spot, but maybe you could say something about that.

Also, I just don't seem to see the five mandates for the Council happening. Could you say something about the status of the Council at this point?

STATEMENT OF MR. TETZLOFF, FEDERAL COUNCIL ON AGING

Ms. **Tetzloff**. I am sorry Kevin Parks is not here to respond to your questions. I have just newly been added to the Council staff as the deputy director. I am getting acquainted with the various roles of the Council on how the Council functions.

I would have to say that I cannot speak to the White House Conference. In fact, I might defer to Carol on that. She may be a little more up to date on any new events relative to that. Relative to the functions of the Council, one of the things that Mr. Parks and I have been working on is some ways to make the Council more effective.

The Council members come together four times a year to meet on various issues. Many of the issues that are discussed in those sessions are brought about by the members of the Council because they feel that they are the important hot hot issues of the day.

I would have to say, like with everybody, the resources are not really that great for the council to function in a very visible way because the resources must go for the payment of travel and people to serve on the Council as well as the staff functions of the Council. When you consider bringing 15 people in four times a year, those resources disappear relatively fast.

In our next meeting, we are going to focus on mental health and the elderly. Hopefully, we will have some kind of report that will come out of that about what some of the issues are and what is currently the status of mental health issues around the country.

Maybe I could answer your questions more explicitly; I don't know.

Mr. **Harris**. I am very happy that you are here to respond because it gives me some sense that the Council is still functioning.

I'm really surprised to realize that it was still in operation. I look forward to reports from the Council.

Ms. **Tetzloff**. There is an annual report that is published every year that is widely disseminated. I would be happy to provide that to you.

Mr. **Harris**. I would like that.

Ms. **Tetzloff**. One of the things that we are talking about doing is ways to expand the mailing list for the annual report because it gives a summary of the various issues that the Council addresses throughout the year.

Mr. **Harris**. In the Act's mandate to the Council I see: review and evaluate Federal policies and serve as a spokesperson on behalf of older Americans in making recommendations to the President, Secretary, and Commission. These are very vital responsibilities.

Ms. **Tetzloff**. Yes, and those recommendations are contained in the annual report. That report then is given to the Commissioner, to the Congress, and to the President.

Mr. **Harris**. Thank you.

Mr. **Olinger**. If I may, I would make a point. I think that one thing that everybody is very conscious of is the shortage of resources.

While we are up here talking at this point—they may still be in; I don't know—the conferees on the Labor/HHS appropriations are meeting downstairs.

I guess my question is for those who work in area agencies and service providers. One of the things that we hear in the House side on the Select Committee on Aging when we try to push for higher funding levels—and there have been greater funding levels—one of the things we hear is that people in Congress are not hearing that there is a priority out there. In other words, they are not hearing from constituents about the need for increased funding in the Older Americans Act.

I know that many organizations regularly testify and present that point of view, but it strikes me as interesting that millions of older Americans can write in, send in postcards, or whatever, the end effect of which is to terminate the catastrophic program, but we do not get the millions of postcards that say: we need another $1 billion for the Older Americans Act.

I guess my question is: to what extent do you think you folks could sort of begin to build that support to put the pressure on us that needs to be put on to build that funding base? The appropriations are meeting now, and there are increases for the first time. That is due to the hard work of a lot of people, but are there reasons that this is not being done or cannot be done?

Mr. **Musselwhite**. While you are thinking about the answer to that question, Senator Pryor has just joined us. As Chairman of this Committee, he certainly needs no introduction. I think he will be making some remarks to us.

STATEMENT OF SENATOR DAVID PRYOR

Senator **Pryor**. I want to first apologize for not being here at 9:30. We are in about 14 different types of meetings and functions at this time and have two or three amendments on the Floor coming up this afternoon.

Our time expires in the neighborhood of 4 o'clock on the budget package and we do not know whether we have the votes for the budget package to send it to the House. We think we will, but it will be very close.

There will be changes in the budget package definitely when the House conferees of Ways and Means and the Finance Committee conferees meet in joint session. That meeting will begin this evening and go through the evening to hopefully work out somehow so that we can meet our deadline and send something to the President.

We could not have planned this workshop on a more hectic schedule than today.

Secondly, I was very appreciative of the response—we all were—of those that we asked to come today to be on the panel. We are very, very grateful to all of you for appearing and to those of you participating in these discussions.

This is the fourth such informal discussion that the committee has sponsored this year. I get a little bit tired, not only as chairman, but also as a Member of the Senate, of having to sit at some big table up there and look out at witnesses 40 yards away testifying. We have felt that we have been very successful in getting real input this year through these informal discussions of those issues, not only the Older Americans Act, but all the issues that effect the elderly in America.

We hope you like these so-called workshops. We hope that they are constructive. We want you to know that we are indeed grateful to those who participated in 1990 in this experiment.

Yesterday on the Senate Floor, Senator Robert Byrd, the President Pro Tempore of the Senate, who is probably the greatest historian the Senate has ever had, had about 15 charts and graphs and talked about the budget crisis that we are in in our country. In my opinion, I would give anything if Senator Byrd would go up to the press gallery sometime when there is a lot of time and ask the press to come to this presentation and just say: okay, I am the professor; you are my students; I am going to give you a course on what has happened to America over the last 10 or 20 years.

One of the things he brought up yesterday reminded me of what you are involved with today. That is the infrastructure of this country. He talked about at length, for example, the 5,719 bridges in our country. He knows all that and doesn't have to refer to notes. He talked all about the infrastructure and the highways and the delivery of goods and merchandize and every system of transportation. We have not built an airport in this country since 1974, for example.

When he was talking about the infrastructure, I thought about this group here today in this room. You are truly the infrastructure for the aging community in our society. You are the infrastructure, and this infrastructure represented in this room today is so very critical to the delivery of services, to the dissemination of ideas, and also for a backup system for those who are out in the States, the counties, the communities, delivering these services.

It is so important that a better system of communication be developed. That is one of key points of having meetings like this, so that we can better decide how to better communicate, how to disseminate ideas, how to exchange ideas, and ultimately, how we can better serve.

Years ago, I was Governor, and I remember we were having a terrible argument in the cabinet one weekend. We were in a budget dilemma in the mid-seventies. One group was wanting this; one cabinet department was wanting that.

I will never forget Dr. Roger Bost, a wonderful man, who just stopped and said: wait a minute; I think we have all lost sight of what we are doing here. He said: we are here for one reason; we are here to serve, and when that mission is somehow lost, then we might as well not be here.

All of you in this room are here to serve, and I am here to serve. We are just very, very grateful that you are here to share ideas and exchange thoughts; to say: here is what is wrong; here is what is right; here is something that is working, and here is something that is not working. The expertise that you have and the commitment that all of you have is very important to us.

Portia, I don't know if you want to make any comments. This is one of your brainchildren here today.

Ms. **MITTELMAN**. Senator, let me just say that I do want to point out again the contributions of Anna Kindermann, Diane Braunstein, and John Monahan. I also want everyone to meet the newest member of our staff, Diana Jones, who works on issues of the ethnic elderly for the Special Committee on Aging.

I have to underscore what the Senator has said, and I think that we are probably at a point where we can conclude. Jim may have some other comments, but we want to thank all the panelists very much for being here.

Mr. **MUSSELWHITE**. I would just like to add my thanks to all the panelists and all of the audience for your participation in helping make this a success. Thank you all very much.

[Whereupon, at 12:04 p.m., the committee was adjourned.]

[The prepared statement of Linda M. Rhodes, Pennsylvania Department on Aging, submitted for the record, follows:]

Statement

of

Linda M. Rhodes

Secretary

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF AGING
Harrisburg, Pa. 17101

before the

Older Americans Act Workshop: "The Administration on Aging: Meeting the Challenge of a Graying America?"

October 18, 1990

STATEMENT FOR THE RECORD

Dear Senators Pryor and Heinz:

Thank you for the opportunity to present the views of the Pennsylvania Department of Aging regarding the administrative implementation of the Older Americans Act. We have prepared a brief response to each of the issues raised in your correspondence of September 28, 1990.

AoA Resources and Staffing

Although we do not have precise figures, we know that AoA has lost a significant number of staff positions over the past decade. We have seen the Regional Office, which is our primary point-of-contact, decline by approximately one-third during this time period. This reduction has occurred while the number and complexity of Aging issues has been growing.

Much of the responsibility for AoA's analytical and educational role has been delegated to private organizations through awards made under the Title IV Discretionary Grants Program. We are strong supporters of Title IV, but it was intended to supplement, not replace, the direct capacity of AoA to provide educational and consultative assistance. Further, the products developed under Title IV grants often go unnoticed or underutilized because AoA does not have the staff or resources to effectively analyze them or "market" the products to state and local organizations.

In general, our experience is that AoA staff are interested and cooperative, but we do not turn to them as a primary resource for technical assistance, issue analysis or educational mentorship. Staff are spread very thin, and their time and attention are focused, to a large degree, on ensuring that paperwork requirements are satisfied.

Our intent is not to be critical of AoA, but to express our opinion that AoA needs more staff who can provide expert assistance.

Organizational Placement of AoA

Elevating the organizational placement of the Administration on Aging will increase the probability of decisive action. We can draw from the history of our own agency in arriving at this conclusion. In Pennsylvania, the State Unit on Aging has been a cabinet level agency since 1979. Prior to that time it was an Office within the Department of Public Welfare. The pros and cons of the organizational change were hotly debated before the change occurred, but it is now well accepted. Because of our organizational placement, the legislature has someone to hold accountable for all issues affecting the elderly, and we have legitimate authority to be a broker in issues which cut across several Departments -- issues like long term care and transportation services.

Given the growing number of older people in our nation and the far-ranging implications of that population shift, we need an Administration on Aging which can be a forceful advocate on cross-cutting issues. In our opinion, elevating the status of the Commissioner to that of Assistant Secretary would improve the probability of that happening.

Technical Assistance

AoA has attempted to compensate for staff reductions by funding private organizations as Resource Centers for providing technical assistance to State and Area Agencies on Aging. This strategy has been at least partly successful, and we receive considerable assistance from some of the Centers, notably the National Association of State Units on Aging (NASUA).

It would be desirable, however, if AoA were to increase its capacity to directly provide technical assistance. This would require hiring more staff with expert knowledge and providing them with resources to do their jobs effectively.

When we have contact with AoA it is usually by telephone or written Information Memoranda. These are very limited methods of communication. AoA staff simply do not have the time or travel budget to visit our offices or attend conferences and meetings which would enable them to build relationships, understand our issues and provide effective guidance.

As an example, during the past year AoA has issued several Information Memorandums. One deals with Medicare Automated Response Units, another with the Employment and Training Administration, and a third deals with SSI and relationships with the Social Security Administration. Each of these Memorandums represent an attempt by AoA to improve coordination at the federal level and encourage corresponding actions at the state and local levels. They each contain good information. Just passing good information along, however, isn't enough.

In the private sector, a company that produces a good product but does not have an effective sales force will fail. This is analogous to AoA's situation. AoA produces good ideas, but it has no sales force to help get those ideas implemented.

AoA could improve its effectiveness by hiring staff, preferably from within the network, who can understand the environment in which we work and provide personalized technical assistance.

Data Collection

AoA collects enough numbers and periodically issues statistical reports, but the numbers have no meaning without timely analysis. AoA is only able to minimally interpret the data, and there are serious questions about whether the methodologies and definitions used by the various state and area agencies which report the information allow for valid comparisons. We would like to be able to compare our performance to that of other states, but we do not believe that the current reporting system is very useful for that purpose.

Data collection might be improved if AoA were to establish an interactive computer link among the reporting agencies. This would require a significant investment in hardware and systems development, but the use of such technology is certainly not uncommon in other sectors. An interactive computer link could also facilitate communication among agencies and the formation of technical assistance networks through electronic bulletin boards.

Coordination With Other Federal Agencies

The role of AoA in interagency coordination would be facilitated by elevating the position of the Commissioner of AoA to an Assistant Secretary level and providing personalized technical assistance to States to ensure follow through on coordination initiatives. We would also suggest that a variety of interagency workgroups or councils be formed and that these be chaired by AoA.

Further, given the significant implications of "Graying America," we believe that it would be warranted to establish an aggressive program for "loaning" staff among agencies which have responsibility for Aging issues. This would involve reciprocal agreements whereby AoA staff, State Unit on Aging staff, AAA staff, etc. could "trade" positions with staff in SSA, HUD, etc. for temporary assignments lasting six months to one year. This would help "gerontologize" other networks as well as improve the technical expertise available to the Aging network.

The Intergovernmental Personnel Loan Program is not a new concept, but it has not been aggressively implemented. It could be a significant tool for enhancing coordination -- especially if federal hiring freezes continue.

Duties Set Forth Under Title II

The duties described for AoA under Title II are appropriate and sufficiently broad in scope. The issues are the effectiveness of their implementation and the level of resources which has been provided to AoA.

Federal Council on Aging

We do not have any interaction with the Federal Council on Aging. We do, however, occasionally see reports which it originates.

We believe that it would be useful for the Council to establish direct linkages with the Advisory Committees which are required under the OAA for each State Unit on Aging and Area Agency on Aging. This could lead to a strong nationwide network of Advisory Councils.

We thank you for the opportunity to submit suggestions and we look forward to participating with you in future events related to the reauthorization of the Older Americans Act.

Sincerely,

Linda M. Rhodes

Linda M. Rhodes
Secretary
Pennsylvania Department of Aging

10/17/90